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ABSTRACT

When an individual or family seeks counseling, assessment information ensures that the counseling professional understands the struggles, difficulties, and strengths of the client(s). An array of assessment issues for various populations and various mental disorders are examined in this series of articles. The hope is that the articles will provide information that will enhance the clinician's assessment abilities and, perhaps, lead to a broadening of ideas and consideration of alternate methods of assessment. A wide range of issues is covered here: the weakness of the traditional concept of motivation, the ways in which assessment affects children and adolescents, the intricacies of diagnosing certain conditions, the interrelated nature of the family and the individual, and assessment concerns in couples counseling. Specific topics examine assessment concerns regarding substance abuse treatment, self esteem in adolescents, gifted minority children, at-risk youth, sexual desire disorders, premenstrual dysphoric disorder, gender differences in schizophrenia, the effects of attention deficit hyperactivity disorder on families, stepfamilies, premarital counseling, and couple readiness in divorce. It is argued that assessment should be an ongoing process that provides the client and the counselor with information regarding progress toward their goals. (RJM)

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ED 410 494

Assessment and Context: Consideration of Client and Environmental Factors within the Assessment Process

Lynda K. Black, Editor

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Introduction

The diversity in family life and society warrants an acknowledgment, on counselors' part, of the rich complexity of clients' lives. When an individual or family seeks counseling, information gathered insures the counseling professional understands the struggles, difficulties, and strengths of the individual or family. Assessment is one method of gathering information that has been useful not only for counselors and mental health professionals but also clients.

As Hood and Johnson (1996) point out, any assessment method or instrument is a source of information. This information, when combined with other sources, helps the counselor understand the client's life and experience. Assessment is often the first step in working with an individual, couple, or family. Assessment provides the clinician an opportunity to understand the presenting issue(s) and the context in which the issue(s) occurs. The initial assessment often results in the client developing a better understanding as well. Ideally, assessment is an ongoing process that will assist the client(s) and the counselor with information regarding progress toward their goals.

These series of articles examine an array of assessment issues for various populations or mental disorders. The hope is that the articles will provide information that will enhance the clinician's assessment abilities. Several articles may lead to a broadening of ideas and consideration of alternate methods of assessment.

In the papers that follow, issues related to assessment are addressed. The first paper, "Determining Motivation for Change in Substance Abuse Treatment," is a discussion about the weakness of the traditional conceptualization of motivation. An innovative schema of motivation is then offered. This shift, along with two methods of assessing motivation will challenge the clinician to rethink how one's own views may limit clients' progress.

Three articles focus on how assessment affects children and adolescents. "Self Esteem Assessment in Adolescents" provides an overview of seven instruments that assess self-esteem. The strengths and weaknesses of each are discussed. "The Country's Hidden Treasure: Identifying Gifted Minority Children" provides a compelling argument for alternate methods to identifying gifted children since the currently widely used intelligence tests often fail to identify children of color who show promise. Several alternate methods to intelligence test scores are presented. Similarly, the impact of labeling is addressed in "Assessing "At-Risk" Youth: Implications for Working Within a DSM World." This article is a discussion of the pitfalls of labels.

Three other papers also discuss diagnoses. "Sexual Desire Disorders" addresses the difficulty in assessing and treating Hypoactive Sexual Disorder and Sexual Aversion Disorder. "Assessment and Treatment of Premenstrual Dysphoric Disorder" is a discussion of the societal and cultural beliefs and attitudes regarding this diagnosis and the difficulty in diagnosing this

medical disorder. "Gender Differences in the Assessment of Schizophrenia" explores the gender differences in age of onset, treatment, and prognosis for people diagnosed with schizophrenia.

Next, exploration of the interrelated nature of the family and individual occurs in "Assessing the Effects of ADHD on the Family" and "Assessment of Adolescents in Stepfamilies: Using a Developmental Framework." These two articles provide information on appropriate methods of assessment for specific situations. This is valuable information for clinicians.

The last two articles relate to couples, "Assessment in Premarital Counseling and Premarital Preparation Programs" and "Assessment of Couple Readiness in Divorce and Practical Implications for Counselors." The article on premarital counseling reviews several programs and current assessment techniques in existence for premarital counseling. The article for assessment of readiness for divorce increases the depth of understanding for couples' contemplating the end of a marriage. A specific model for assessing readiness in divorce is the focus.

As seen by the titles, a wide array of topics is included in this monograph. The unifying theme is an effort to enhance clinicians' understanding of assessment as it relates to specific populations or issues. If clinicians' understanding is enhanced, clients will benefit. That is one goal of preparing this monograph. Another goal is provocation of thought. If that goal is achieved, we have accomplished much. Happy reading.

References

Hood, A. B., & Johnson, R. W. (1997). Assessment in Counseling. Alexandria, VA: American Counseling Association.

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Running Head: DETERMINING MOTIVATION FOR CHANGE

Determining Motivation for Change in Substance Abuse Treatment

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Determining motivation for change in substance abuse treatment

Overview

Determining a client's motivation to make positive changes in his or her life is an important part of substance abuse treatment. Indeed, motivation is considered a *sine qua non* for treatment success. Yet most motivational assessments have been informal, even retrospective, and based rather precariously on treatment compliance and success. In other words, the client who does not adhere to treatment and fails to achieve sobriety is all too easily dismissed as being unmotivated (Miller, 1985).

Fortunately, the concept of motivation has been refined in the past decade or so. The question is changing from *whether* a client is motivated to *what* motivates the client. The traditional view of motivation as an all-or-nothing quality is being challenged by an awareness of motivation as a dynamic, interactive process involving stages (Miller, 1985; Miller & Rollnick, 1991; Prochaska & DiClemente, 1982).

This article will examine the pitfalls inherent in the traditional concept of motivation, then look at the current reformulation. Two assessment strategies will be presented: a cost-benefit analysis and an intervention model based on the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) instrument. This will be followed by a discussion of what to do when the SOCRATES indicates the client is in the pre-contemplative, or first, stage. Too often clients at this level have been labeled as unmotivated, placing them at risk for early termination from substance abuse treatment. Certainly such clients present a challenge to clinicians, but hopefully this article will persuade readers to remove the term "unmotivated" from their vocabularies.

Discussion

The traditional trait model views motivation as a client attribute. This perspective is subject to numerous criticisms, chief among them being that blame for treatment failure tends to fall squarely on the client (Miller, 1985). Indeed, 72 percent of hospitals treating alcoholics held the patient solely accountable for negative outcomes, with only 11 percent admitting even partial responsibility (Moore, 1971). Typically, clients are judged to be motivated if they accept the counselor's view of the problem. In traditional, 12-step based substance abuse treatment such acceptance usually includes taking on the self-label of alcoholic, succumbing to the "sick role" dictated by the disease model, agreeing to the central concept of powerlessness, and admitting to the concordant need for external help from some "Higher Power". A high degree of subjective distress is considered prognostic, since a client is expected to have "hit bottom", to have squeezed every last drop of pleasure out of their addiction, before they are "willing to go to any lengths" to end their suffering. "Going to any lengths", an oft-used AA phrase, generally means complying with treatment (Miller, 1985).

Conversely, a client who does not accept the counselor's view of the problem, evinces little or no distress, and does not comply with treatment is labeled resistant, in denial, and, worst of all, unmotivated (Miller, 1985). In fact, a client may be "unmotivated" to work with a particular counselor due to a personality clash: the counselor may be suspicious, hostile, moralistic, or lacking empathy. Or a counselor may be "unmotivated" to work with a particular client simply because that person reminds them in some superficial way of a previous treatment failure.

Miller and Rollnick (1991) define motivation as "the probability that a person will enter into, continue, and adhere to a specific change strategy" (19). The chief effect of this definition is to shift away from the passive adjective "motivated" to the active verb "to motivate": "It is the counselor's responsibility ... to motivate—to increase the likelihood that the client will follow a recommended course of action toward change" (19). Motivation can be seen as an interaction between the client, the counselor, and the environment. It is a dynamic state, a process, rather than a static personality trait. The focus is placed on behavior rather than on some internal state of readiness.

From this perspective the client is always motivated. Even if this motivation takes the form of using behavior, such behavior can be diagnostic. Is it environment? Peer or family influence? Fear of failure? Fear of withdrawal? Lack of support? Lack of knowledge? Assessing the motivation to continue abusing substances can be as helpful as determining the motivation to change (Zweben, 1993).

If motivation is a dynamic process, then the very assessment of it can cause change (Miller, 1991). Two methods of motivation assessment may increase the probability of making positive behavioral changes. First, the counselor may conduct a cost-benefit analysis with the client. An instrument such as the Michigan Alcoholism Screening Test (Selzer, 1971) can be used to determine the costs of continued use – the negative consequences motivating the client to change. The Alcohol Expectancy Questionnaire (Brown, Christiansen, & Goldman, 1987), which looks at the reinforcing effects, or benefits, of use, would reveal the motivations to not change. Of course, motivational leverage is supplied when the perceived costs outweigh perceived benefits.

The cost-benefit approach is best suited for a client in the contemplative stage (discussed below), where the possibility of making changes is being considered.

Second, the counselor may administer the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) developed by Miller (as cited in Isenhart, 1994) to assess the Prochaska-DiClemente stages of change with regard to substance abuse. Prochaska and DiClemente (1982) suggest five stages in the change process: precontemplation, where the client is unaware of or unwilling to admit to a problem; contemplation, where the client is considering the possibility; determination, where the client makes a commitment to action and prepares a plan; action, where the plan is actually implemented; and maintenance, where the changes are sustained or, in the case of relapse, the process is recycled. As noted by DiClemente (1991), the client may come in for treatment at any point in the cycle; SOCRATES can help the counselor determine where he or she is. "Motivation" implies motive and movement: as the client moves along the continuum of change, his or her motives change as well. Different interventions will be appropriate given a client's level of motivation.

DiClemente (1991) subcategorizes the precontemplative client, the type traditionalists are most likely to label "unmotivated", into "the 4 R's": reluctant, rebellious, resigned, and rationalizing. The reluctant precontemplators lack knowledge or do not yet want to consider change: they are not fully conscious of the problem. DiClemente suggests sensitive, empathic feedback for these clients; sometimes they simply need more time. Rebellious precontemplators are invested in making their own decisions. Since they often resist being told what to do, providing them with choices may

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be the best strategy. Resigned precontemplators have given up on the possibility of change. With these clients, a counselor might work on instilling hope and examining barriers to change. Rationalizing precontemplators are more intellectual than their emotion-driven rebellious counterparts; these clients have all the answers and know all the angles. DiClemente suggests empathy and reflective listening for this group.

Conclusion

Miller's (1985) definition of motivation as a dynamic, interactive process takes the onus off of the client to conform to cookie-cutter treatment approaches. The challenge falls squarely on the counselor to determine what motivates the client and enhance the probability of change-seeking behavior. Assessment strategies such as the cost-benefit analysis and SOCRATES provide objective measures that aid the counselor in these tasks. Interventions based on the client's stage level of change readiness may prove more efficacious, as the counselor adapts to the client's needs.

Given the Pygmalion effect – that expectancies tend to influence outcomes, and labels can become self-fulfilling prophecies – counselors would be well-advised to consider all clients as motivated. As one professor likes to say, the only unmotivated clients are dead clients (J.S. Hinkle, personal communication, Fall, 1994). To be alive is to be motivated some way or other. In counseling, motivation is something that happens, not a personal attribute. Noncompliance with a particular treatment strategy or program by no means proves the client is unmotivated to change substance abusing behavior.

References

Brown, S.A., Christiansen, B.A., & Goldman, M.S. (1987). The Alcohol Expectancy Questionnaire: An instrument for the assessment of adolescent and adult alcohol expectancies. Journal of Studies on Alcohol, 48, 483-491.

DiClemente, C.C. (1991). Motivational interviewing and the stages of change. In W.R. Miller & S. Rollnick (Eds.), Motivational interviewing: Preparing people to change addictive behavior (pp. 191-202). New York: Guilford.

Isenhart, C. (1994). Motivational subtypes in an inpatient sample of substance abusers. Addictive Behaviors, 19, 463-475.

Miller, W.R. (1985). Motivation for treatment: A review, with special emphasis on alcoholism. Psychological Bulletin, 98, 84-107.

Miller, W.R., & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: The Guilford Press.

Moore, R.A. (1971). Alcoholism treatment in private psychiatric hospitals: A national survey. Quarterly Journal of Studies on Alcohol, 32, 1083-1085.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research, and Practice, 19, 276-288.

Selzer, M.L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127, 1653-1658.

Zweben, J.E. (1993). Recovery oriented psychotherapy: A model for addiction treatment. Psychotherapy, 30, 259-268.

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Self-Esteem Assessments for Adolescents

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RUNNING HEAD: Self-Esteem

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Introduction

A variety of self-esteem inventories for adolescents are available to professionals. It is often confusing, however, to determine which inventory would be most helpful with a given individual. Some of the measures provide a unidimensional view of self-esteem while others generate a factorial report. Self-esteem has been shown to have a direct link with future success in life, so it is important to both be able to recognize and assist in elevating the self-esteem in adolescents (Mruk, 1995). This paper will provide a brief summary of the various instruments and examine their differences, strengths, and weaknesses. Information on the validity, reliability, and norming populations is included for all assessments. This is by no means an exhaustive list of current inventories; it is instead, a selection of a few well-known instruments in addition to some newer ones that are now available.

Defining the term self-esteem is difficult at best. As it is often viewed as a construct, it becomes an intangible object that must be described in terms that attest to personality traits and features (Mruk, 1995). Definitions point to the affective, behavioral, or cognitive component of self-esteem. Depending on one's theoretical viewpoint, the definition changes subtley to reflect the main points of each theory. In addition, authors often use self-concept to describe a personality construct that is remarkably similar to self-esteem. Bracken and Howell (1991) examined three instruments related to this construct and determined, based on comparable resulting scores, that each assesses the same element, whether it is called self-esteem, self-worth, or self concept. For the purposes of this paper, the construct of self-esteem will refer to a self-evaluative process that is reflected in behavior, thoughts, and/or feelings. Additionally, it will be assumed that each instrument assesses the same general

construct. It is strongly recommended, however, that an examination of the theoretical base upon which the inventory is based is thoroughly inspected prior to selection.

The Inventories

The Coopersmith Self-Esteem Inventory (CSEI) was originally developed in 1967 for use with children 8-15 years old. Based on theories from social psychology, it includes 50 items which are answered in a forced choice format. The inventory provides information on four different scales (general, social self-peers, home-parents, school-academic) as well as providing a total self-esteem score. The original norm group included over 8,000 students from the state of Illinois, but it has since been shown to be helpful with a variety of populations. Factor analyses have tended to favorably support the scales as being related to self-esteem. Reliability coefficients are adequate, usually .80 or higher and internal consistency results have ranged from .80 - .92. In addition, predictive validity has been found to be good as well (Adair, 1984).

Published in 1981, the Culture-Free Self-Esteem Inventory (CFSEI) was created to measure the affective area of self-esteem. It is designed for use with students in grades three through nine to produce a multidimensional analysis. Four scales are included (general, social/peer, academics/school, parents/home) and a total score is provided as well. Little information is provided regarding its use with various populations. The sixty items are answered in a forced choice fashion. The instrument has been shown to have adequate reliability, with coefficients ranging from .79 - .92 for test-retest and .66 - .76 for internal consistency. Concurrent validity has also been found by comparing the inventory with other measures of self-esteem (Riggs, 1985).

One of the newest measures of self concept is the Multidimensional Self Concept Scale (MSCS), based on a behavioral view of self concept. It is designed to elicit scores on six factors (affect, social, competence, family, physical, academic) as well as provide an overall score. Published in 1992, it was normed on 2,500 fifth through twelfth graders in 17 sites throughout the United States. The sample closely matches the national population on gender, race, ethnicity, and region. The test includes 150 questions which are answered using a four-point Likert scale and produces very high reliability coefficients for the total scale, ranging from .97 -.99. Test-retest coefficients are slightly lower, with scores from .73 - .90. Extensive concurrent and construct validity tests were conducted with moderately correlated results (Bracken, 1992).

The Piers-Harris Self-Concept Scale (PHSCS) is an 80 item forced choice, multidimensional inventory which provides information in six general areas (behavior, intellectual and school status, physical appearance/attributes, anxiety, popularity, happiness/satisfaction). It is designed to measure the self-attitudes of students in grades four through twelve and was originally normed in 1964 on a large group of students from a small district in Pennsylvania. Although the original norms have not been updated, other studies have found the scale useful with a variety of populations. Internal consistency coefficients range from .88 -.93, while test-retest results provide a mean coefficient of .75, both indicating adequate to very good reliability. Construct validity results have been found to be moderately positive, while factor analyses have resulted in conflicting conclusions regarding the actual multidimensionality of the scale (Wylie, 1989).

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Developed in 1962, the Rosenberg Self-Esteem Scale (RSES) is the only true unidimensional scale being examined in this paper. It contains ten questions which assess the feelings of high-school students using a four-point Guttman-Scale format. The norm group contained over 5,000 high-schoolers of diverse ethnicity and subsequent research has included an ever-growing multicultural population for which this instrument may be used. Internal consistency tests have produced a reliability coefficient of .92, with test-retest results producing correlations of .85 - .88, both indicating good results. Construct validity research has generated positive results as well (Corcoran and Fischer, 1987).

The Self-Esteem Index (SEI) is another new addition to this area of assessment. It was published in 1991 to provide results on four scales (perception of: familial acceptance, academic competence, peer popularity, and personal security) as well as an general measure of self-esteem. The eighty items are answered using a four-point Likert scale and designed for use with students ages 7.0 to 18.11. It was normed using over 2,400 students from almost half of the states in the nation and is comparable to the U.S. population in race, gender, region, ethnicity, socioeconomic status, and parent education. Internal consistency displays reliability coefficients from the .80's and higher. No information is provided on test-retest reliability. At the time of publication, validity had not been well established, with data provided only from small samples with varying results (Huebner, 1992).

Another well-established assessment is the Tennessee Self-Concept Scale (TSCS), published in 1964 for use with students age twelve and higher. The inventory contains 90 items that are answered on a five-point Likert scale. This behaviorally and socially based instrument produces scores for eight scales (identity, self-satisfaction, behavior, physical self,

moral-ethical self, family self, social self). The norm group consists of 626 people of varying age, educational, and economic areas. The test-retest reliability coefficients range from .60 to .92 which indicates below average to very good results. Examination of construct validity has produced varying results as well, but most are considered adequate (Walsh, 1984).

Discussion and Conclusion

All of the inventories described above are available for use by trained professionals in the helping professions. Most take twenty to thirty minutes to administer and are relatively easy to score. In addition, the PHSCS and TSCS have computer scoring programs available to the public. All can be given to an individual or in a group situation and none require a reading level above fifth grade. Lie scales are included for the TSCS and CSEI to insure the validity of the taken inventory. Books on assessment usually recommend reliability coefficients above .70, with .90 and above being ideal for stable constructs, while validity coefficients should be above .30 to be considered adequate (Hood & Johnson, 1991). Reliability coefficients are highest for the MSCS, PHSCS, CSEI, and RSEI, but all except the TSCS fall in the acceptable range of reliability. For validity, factor analyses for the TSCS, MSCS, and PHSCS seem to need more extensive investigation.

Each instrument has both its strengths and weaknesses. The CSEI is a forced choice assessment which may not allow for enough diversity in answers. The shortness of the instrument, however, may be beneficial for use with teenagers who may not want to take an extended test. The CFSEI is available in several other languages which makes it an option for use with a broader population range. Problems for this instrument arise from its possible

lack of generalizability to a non-Canadian population. The newest assessment to be reviewed, the MSCS benefits from its large norm group which mimics the U.S. population. Unfortunately, its length may be a deterrent for many professionals.

The PHSCS is another forced-choice assessment which has items that overlap in its factors, causing a potential difficulty when conducting research. The assessment, nevertheless, is considered to be one of the most trusted in the field of self-esteem. The shortest of the instruments is the RSES, which is both a benefit and a problem. While it is very easy to administer and score, the unidimensionality may not be specific enough for many counselors. The SEI, the other new instrument, provides no test-retest data, again creating a problem for research use. Its good standardization based on a large, diverse group, on the other hand, leads to its positive use with a variety of populations. Finally, the TSCS provides different forms for counseling and research which allows for specific information for specific uses. The low reliability coefficients and lack of internal consistency results, however, make it a questionable instrument for research.

Seven assessments of self-esteem or self-concept in adolescents have been examined in this paper. Information is provided on reliability, validity, and test usage. The construct of self-esteem has been examined at the cognitive, affective, and behavioral level, and the assessments available reflect this diversity. When deciding what instrument to select, one must examine the intended use, the population being tested, and the usefulness of a particular assessment. All of the instruments have many positive qualities, but each has its own unique strengths as well. Hopefully, the information provided will assist in this difficult decision-making process.

References

Adair, F. L. (1984). Coopersmith Self-Esteem Inventories. In D. J. Keyser & R. C. Sweetland (Eds.), Test Critiques: Volume I (pp. 226-232). Kansas City, MO: Test Corporation of America.

Bracken, B. A. (1992). Multidimensional self concept scale: Examiner's manual. Austin, TX: Pro-Ed.

Bracken, B. A. & Howell, K. (1991). Multidimensional self concept validation: a three-instrument investigation. Journal of Psychoeducational Assessment, 9, (4), 248-252.

Corcoran, K. & Fischer, J. (1987). Measures for clinical practice: A sourcebook. New York: The Free Press.

Huebner, E. S. (1992). Self-Esteem Index. In Jack J. Kramer & Jane C. Conoley (Eds.), The Eleventh Mental Measurements Yearbook. Lincoln, NB: The University of Nebraska Press (pp. 807-808).

Hood, A. B & Johnson, R. W. (1991). Assessment in counseling: A guide to the use of psychological assessment procedures. Alexandria, VA: American Counseling Association.

Mruk, Chris. (1995). Self-Esteem: Research, theory, and practice. New York: Springer Publishing.

Riggs, J. M. (1985). Culture-Free Self-Esteem Inventories. In James V. Mitchell (Ed.), The Ninth Mental Measurements Yearbook. Lincoln, NB: The University of Nebraska Press (pp. 424-425).

Walsh, J. A. (1984). Tennessee Self Concept Scale. In D. J. Keyser & R. C. Sweetland (Eds.), Test Critiques: Volume I (pp. 663-672). Kansas City, MO: Test Corporation of America.

Wylie, R. C. (1989). Measures of self-concept. Lincoln, NE: University of Nebraska Press.

Running head: THE COUNTRY'S HIDDEN TREASURE

The Country's Hidden Treasure: Identifying Gifted Minority Children

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The Country's Hidden Treasure:
Identifying Gifted Minority Children

It is believed by many researchers on the subject that gifted individuals are to be found in all races and in all socioeconomic levels (Borland & Wright, 1994). However, the present educational system in this country has failed to identify many children of color who show promise for achievement. Minority children are severely underrepresented in gifted programs in this country. This reality is a multifaceted problem that has only recently become a focus for researchers and educators.

Present Difficulties and Factors

The difficulties inherent in defining such a complicated construct as 'gifted' contribute to the present bias. In practice this very complex construct has been reduced to a single factor: specific academic aptitude. Furthermore, this measure is arrived upon by the use of a single tool: the I.Q. test. Intelligence tests have been widely criticized for discriminating against anyone who is not white and middle or upper-middle class, yet they still remain the primary tool used to identify children with special academic promise (Bolig & Day, 1993). Also, children from homes with lower socioeconomic status are also less likely to be identified as gifted (Borland & Wright, 1994). Since many of the poor in the United States are also people of color, these facts make it terribly difficult for children

with high academic promise from these circumstances to be given the same opportunities as their more affluent, white counterparts.

The literature is replete with all of the difficulties to be found in the present accepted ways of identifying gifted children. However, the majority of present practice in this country's schools still depends on the I.Q. test to identify the 'best and the brightest.' Obviously, the gap between research and practice is a very wide one (Ford & Harris, 1991).

Alternatives

Innovative methods are being investigated in different areas of the U.S. These include more comprehensive assessment methods that may or may not include both traditional and alternative testing instruments. The ones that will be discussed have been developed primarily to better identify gifted children whose identification escapes present standard methods.

In a discussion on how to better identify African American children with superior abilities, Ford & Harris (1991) advocate for multi-modal and multi-dimensional assessment. "Multi-modal assessment... includes an integration of standardized, non-standardized, qualitative and quantitative instruments when assessing any child believed to have superior abilities" (Ford & Harris, 1991, pp. 25). Multidimensional assessment addresses the concept that being gifted can go beyond clear cognitive ability and can include other dimensions of intelligence.

The following three projects are examples of programs that use multi-modal and multi-dimensional assessment.

Coleman (1994) describes a project entitled Early Assessment for Exceptional Potential in Young Minority and/or Economically Disadvantaged Students (EAEP) which uses Portfolio Assessment as its method. Portfolio Assessment begins by this project's identification of "primary identifiers of exceptional potential which include (italics added) I. exceptional learner (acquisition and retention of knowledge)... II. exceptional user of knowledge (application of knowledge)... III. exceptional generator of knowledge (individual creative attributes)... IV. exceptional motivation (individual motivational attributes)" (Coleman, 1994, pp. 66). Teachers are trained through the use of videotapes of children manifesting these behaviors in order to better explain what these primary identifiers look like when illustrated by a child. Teachers keep portfolios on children which include observations of the child made by the teacher, surveys completed by family members and/or others close to the child, examples of products produced by the child in the course of educational assignments or at home, and even observations made by other students. Teachers then use these portfolios to identify children who are gifted and develope what is called an Action Plan. These include identifying gifted students, exploring options for the child, identifying possible resources, and specific assignments for the child.

J.B. Griffin (1992) writes about an organization entitled "A Better Chance, Inc." which identifies itself as a national academic talent search agency. This agency devotes itself to the task of finding gifted children of color from all over the country. Several hundred children each year are identified and then given the opportunity through scholarship services to study throughout high school in some of the most prestigious private day, boarding schools, and public high schools in the U.S. The process begins with applications given to 400 "feeder schools" with whom the agency has established a relationship. Teachers are encouraged to identify promising students and encourage them to apply. A lengthy application is completed utilizing applicants' responses, parental statements, transcripts, recommendations, and the completion of a test called the SSAT (Secondary School Admission Test). Then the agency uses an already established set of guidelines, supported by their research, to pick the children who are most likely to benefit from the services that they offer. This is obviously an example of using alternative methods to identify gifted minority children.

Another example is called Project Synergy which is funded by the U.S. Department of Education and for which the research and development is conducted at Teachers College at Columbia University. It has been developed to identify economically disadvantaged students, many of whom are also those of minority

status (Borland & Wright, 1994). The methods described in this project were developed and used with children attending a school in central Harlem, New York City. The student body is three-quarters Black and one-quarter Hispanic with nearly all of the children being characterized as being economically disadvantaged. The first phase of the process involves screening and consists of the use of a variety of assessment tools, both nontraditional and standardized. These include classroom observation, multi-cultural enrichment activities, teacher identifications, portfolio assessments, and the use of the Draw-a-person test. The combination of the proceeding is used to select a pool of children who illustrate gifted potential. Phase II involves gaining further data about each of the children identified and again uses both nontraditional assessment tools and standardized tests. These include literature-based activities, the Test of Early Mathematics Ability-2, the Test of Early Reading Ability-2, the Peabody Picture Vocabulary Test, an interview with the child, and the use of Dynamic assessment. Dynamic assessment is a tool mentioned often in the literature as an alternative in identifying gifted children and is based on the rationale that it makes more sense to test a child on what he or she can accomplish with limited instruction than to test a child on what he or she already knows. The end result of Phase II is an academic profile of each child identified by Phase I. Phase III attempts to identify the children who

may display gifted potential. Children in each cohort identified are given the opportunity to receive services for gifted children that have been developed for this project and that include special classes for the children and parent workshops. Qualitative data is available for the project and demonstrates the success of Project Synergy in launching several of these children to schools for the gifted. Quantitative data is also available and illustrates the high scores of the children on the Kaufman Test of Educational Achievement and good scores on the Stanford-Binet. In short, the results from this project are encouraging.

Some researchers are also experimenting with individual assessment devices that have been developed solely to locate gifted children. One of these is called 'The Screening Assessment for Gifted Minority Children (SAGES).' In a study where SAGES was given to 162 elementary school children who were made up of both Hispanic-American and Anglo-American children, Tallent-Runnels and Martin (1992) found the test to be fair for identifying gifted children of both ethnic backgrounds. The test focuses on three types of giftedness: reasoning, information acquired in schools, and divergent production. Hamilton (1993) describes an assessment tool for African American children using a behavioral assessment technique called 'The Gifted Children Locator' developed by the author. The assessment scale has been developed specifically to locate

gifted African American children from their own cultural perspective. There is a Gifted Children Locator scale for Parents (GCL-P) and a Gifted Children Locator Scale for Teachers (GCL-T) that are administered in order to identify gifted behaviors of African American children. The author discusses reliability, validity, and standardization issues with the GCL-P and the GCL-T, all of which appear to be favorable.

Conclusions

Obviously, a lot more work remains to be done before educators and researchers can believe that methods used to identify gifted children are fair and comprehensive. The most widely used methods are obviously not working, and experimental methods are extremely time-consuming and not backed by enough research support yet. The gulf between research and practice in locating this country's hidden treasure still remains wide. However, efforts are being made in research and in practice to build a bridge over the gulf.

References

Bolig, E. & Day, J. (1993). Dynamic assessment and giftedness: The promise of assessing training responsiveness. Roeper Review, 16, 110-113.

Borland, J. & Wright, L. (1994). Identifying young, potentially gifted, economically disadvantaged students. Gifted Child Quarterly, 38, 164-171.

Coleman, L. (1994). Portfolio assessment: A key to identifying hidden talents and empowering teachers of young children. Gifted Child Quarterly, 38, 65-69.

Ford, D. & Harris, J. (1991). Black students: "At promise" not "at risk" for giftedness. Journal of Human Behavior and Learning, 7, 21-29.

Griffin, J. (1992). Catching the dream for gifted children of color. Gifted Child Quarterly, 36, 126-130.

Hamilton, S. (1993). Identifying African American gifted children using a behavioral assessment technique: The Gifted Child Locator. Journal of Black Psychology, 19, 63-76.

Tallent-Runnels, M. & Martin, M. (1992). Identifying Hispanic gifted children using The Screening Assessment of Gifted Elementary Students. Psychological Reports, 70, 939-942.

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Running head: ASSESSING "AT-RISK" YOUTH

Assessing "At-Risk" Youth: Implications for Working Within a DSM World

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Assessing "At-Risk" Youth: Implications for Working Within a DSM World

In general, counseling adolescents is often viewed as more difficult, challenging, and less fulfilling than counseling adults or younger children (Biever, McKenzie, Wales-North, & Gonzalez, 1995). Many counselors, parents, teachers, and other adults may anticipate that their interactions with adolescents will involve conflict and frustration, and they approach adolescents accordingly. This belief is further compounded when an adolescent is deemed as "at risk" or "delinquent," possibly because he or she has not adhered to adult norms of behavior. Much of the literature on the treatment of clients who exhibit delinquent behaviors has concluded that "nothing works" and that low treatment success has led many mental health professionals to "virtually give up" (Borduin, 1994, p. 20). This is especially true when clients are given the diagnosis of Conduct Disorder. In order to provide effective counseling when working with youth, it is important to get beyond the labels and focus on the individuals behind the behaviors. It is also essential for counselors to work with other adults in their clients' lives, such as parents and teachers, to help them effectively interact with the individuals and not with negative stereotypes.

According to Raybeck (1991), one of the purposes of labeling individuals, whether with positive or negative labels, is to "increase the predictability of social life by adding information to the social context" (p. 21). Therefore, diagnosing clients can be seen as a social practice-- one that assigns judgments and depersonalizes the individual (Schwartz, 1991). Many studies have shown that a label, alone, can generate its own "stigma, prejudice, segregation, and self-fulfilling validation" (Schwartz, 1991, p. 1). These effects may be intensified if the label or diagnosis is misused or misunderstood due to inadequate information about the factors leading to the targeted behaviors. Unfortunately, counselors are required to give their clients a label or diagnosis in order to receive funding or insurance reimbursement for services. Therefore, it is the counselor's responsibility to advocate for his or her individual clients while working within the world of the DSM.

Some community agencies allow children and adolescents to qualify for their services based on their behaviors which place them at risk of involvement with the juvenile justice system. These behaviors may also qualify them to receive such diagnoses as Conduct Disorder. With this diagnosis often comes a stigma that may follow the young person and negatively affect others' interactions with him or her. Due to the stigmatizing nature of a diagnosis like Conduct Disorder, counselors may want to consider other diagnoses after completing a comprehensive assessment of the individual. According to the DSM-IV, parental rejection and neglect, inconsistent parenting practices, harsh discipline, physical or sexual abuse, and frequent changes in caregivers are among the factors which may predispose a young person to the development of Conduct Disorder (American Psychiatric Association, 1994). All of these factors represent external stressors that may adversely affect an individual and lead him or her to exhibit a variety of behaviors deemed as delinquent. Therefore, this description of predisposing factors lends support for the possible alternative diagnosis of Adjustment Disorder (with Disturbance of Conduct).

Adjustment Disorder is a less stigmatizing diagnosis than Conduct Disorder, and it appears to be appropriate for any individual going through the transitional periods of childhood and adolescence, in which young persons are prone to experience a variety of stressful events. In support of the pertinence of a diagnosis of Adjustment Disorder for an individual exhibiting delinquent behaviors, Attar, Guerra, and Tola (1994) state that individuals who experience several major negative life events, such as parental divorce, death of a relative, and exposure to violence, are more likely to develop a range of adjustment problems, including academic problems, social withdrawal, and delinquency. Furthermore, individuals who face high levels of chronic, stressful environmental conditions, such as poverty, violence, limited community resources, and weak social support, are more likely than those who grow up under more favorable conditions to exhibit a variety of behavioral and emotional difficulties (Attar et al., 1994). Children and adolescents who are from poor and disadvantaged neighborhoods often lack

appropriate care, and they end up lying, stealing, and fighting in order to survive (Cuban, 1989). Their behaviors may not be in their (or others') best interest, but they may be normal reactions to very abnormal and chaotic environments. These findings are evidence for the importance of a careful examination of the environmental conditions in which an individual lives and the cultural and/or subcultural contexts for his or her behaviors.

The first step in the development of effective counseling involves the formulation of a clear definition of the individual's presenting problem (Tidwell & Garrett, 1994). This can be accomplished with a comprehensive assessment of the various "causal pathways" which led to the onset of delinquent behaviors (Sullivan & Wilson, 1995, p. 11). The causes or precipitating factors of delinquent behavior can be divided into four general categories: individual, family, community, and sociological characteristics, including "subcultural affiliations (e.g. gangs)" (Sullivan & Wilson, 1995, p. 11). All of these factors are interactive and dynamic, and they vary among individuals.

When assessing certain characteristics of the individual that may predispose him or her to engage in delinquent activity, the counselor must look at the developmental level of the client, who may be delayed in one or more of the cognitive, emotional, social, moral, psychosocial, or physical areas of development. The counselor must also assess any academic problems the client may be experiencing. School failure is often correlated with a decrease in a child's self-esteem, and many researchers believe that when legitimate means (such as success in school) of achieving high self-esteem fail, the child may turn to illegitimate pathways to achieve it (Robins, 1991). Another factor to consider when assessing a client's behaviors is the context in which those behaviors occur. Important aspects in the assessment of the context of behaviors include the circumstances under which the behaviors occurred, whether or not the individual was provoked or influenced by others, whether or not he or she is conscious of the consequences of his or her delinquent behaviors, and whether or not the behavior was an intentional act to defy certain norms or authority figures (Raybeck, 1991). Other individual factors in need of

assessment include self esteem, temperament, problem-solving ability, and level of socialization (Sullivan & Wilson, 1995).

Family variables that may precipitate child and adolescent delinquent activity, and therefore, should be carefully examined, include demographic factors (size, composition, and income), criminal behavior by parents, parental or familial discord, alcoholism, and severe and erratic discipline (Robins, 1991). Family expectations for the child and for treatment are also important to assess in order to effectively incorporate the family as part of the treatment process.

Comprehensive assessment must also include the community and sociological variables that impact the young person's life. These variables include the values, norms, and attitudes about delinquent behavior within the community in which the individual lives as well as the general living conditions in which he or she lives. Furthermore, the existence of a "gang subculture," containing its own norms, values, and social controls, can have tremendous influence on a young person's behaviors (Sullivan & Wilson, 1995). The client's peer group, in general, should be examined to detect any influences or pressures to engage in delinquent activity. There tends to be a reciprocal relationship between an individual's association with peers who are engaging in delinquent activity and that individual's own delinquent values and behavior, each influencing, and possibly increasing, the other (Thornberry, 1987). Finally, the stressful environmental conditions mentioned above are also essential aspects of the community in need of assessment.

The counseling profession has long emphasized a model based more on health than on illness, and it is essential for counselors not to allow that position to be compromised by the requirement for a diagnosis or a strict focus on the problems and weaknesses of clients (Rak & Patterson, 1996). It is the counselor's responsibility to assess and help the client identify his or her strengths and resources in order to build on them and generate new possibilities and alternatives to problematic behaviors (Biever et al., 1995). During the assessment process, the counselor can inquire about exceptions to problem situations. One example of this would be

when the problem behavior does not occur or when the behavior is present but is not seen as a problem (Biever et al., 1995). Counselors may also want to examine individual, familial, and community factors that promote resilience in the young person. These include the individual's ability to negotiate solutions to problems, be autonomous, and gain positive attention from others and the family's ability to provide structure and an available support network for the individual (Rak & Patterson, 1996). By evaluating both the causal pathways and risk factors of delinquent behavior and the strengths and resiliency factors of clients, counselors can plan effective, individualized interventions that will help clients overcome barriers and improve their ability to respond to stress or crisis.

According to Sullivan and Wilson (1995), the core of effective intervention is a comprehensive assessment in which the counselor measures the interactive effects of the contributory factors and produces a treatment plan that is tailored to the individual, family, and community. It is imperative that counselors conduct a careful analysis of the etiology of an individual's behaviors and implement an individualized treatment plan working towards finding alternatives to those behaviors. It is equally important that counselors not allow the requirement for a diagnosis to get in the way of a comprehensive assessment and intervention. When problems are attributed solely to deficits within the individual, solutions are likely to be ineffective and possibly exacerbate the problem (Cuban, 1989). Since a diagnosis is based on the clinical judgment of the mental health professional, a comprehensive assessment, including the factors outlined in this paper, seems essential in order to accurately diagnose and provide treatment based on the needs of the individual.

In a world where it is increasingly necessary to provide a diagnosis and a treatment plan that fits that diagnosis, the counselor must remember who his or her client is and focus on the individual sitting in front of him or her rather than on what general intervention is used with a population of people with the same diagnosis (Biever et al., 1995). Because a label is often only descriptive of one part of a young person's experience, a general rule of thumb for counselors

should be to "work with the person, not the label" (Biever, et al., 1995, p. 496). A comprehensive assessment minimizes judgmental classifications of youth and promotes a thorough evaluation of individual, familial, community, and sociological variables which are unique to the client. It may also help the counselor redefine the problematic behaviors not only for the client but also for parents, teachers, and other adults in order to encourage a more positive look at the individual young person and instill a willingness to figure out what works and does not work with that individual. It is incumbent upon counselors to provide supportive environments for their clients and to place value on each individual, holding the expectation that each client can and will succeed in life and reinforcing this expectation with other significant adults in the young person's life (Rak & Patterson, 1996)

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Attar, B. K., Guerra, N. G., & Tolan, P. H. (1994). Neighborhood disadvantage, stressful life events, and adjustment in urban elementary-school children. Journal of Clinical Child Psychology, 23, 391-400.

Biever, J. L., McKenzie, K., Wales-North, M., & Gonzalez, R. (1995). Stories and solutions in psychotherapy with adolescents. Adolescence, 30 (118), 491-499.

Borduin, C. M. (1994). Innovative models of treatment and service delivery in the juvenile justice system. Journal of Clinical Child Psychology, 23 (Suppl.), 19-25.

Cuban, L. (1989). The "at-risk" label and the problem of urban school reform. Phi Delta Kappa, 780-784.

Rak, C. F., & Patterson, L. E. (1996). Promoting resilience in at-risk children. Journal of Counseling & Development, 74, 368-373.

Raybeck, D. (1991). Deviance, labelling theory and the concept of scale. Anthropologica, 33, 17-38.

Robins, L. N. (1991). Conduct disorder. Journal of Child Psychology and Psychiatry, 32 (1), 193-212.

Schwartz, L. (1991). The myth of the at-risk student. Paper presented at the Council for Exceptional Children's Topical Conferenced on At-Risk Chiluren and Youth. New Orleans.

Sullivan, R., & Wilson, M. F. (1995). New directions for research in prevention and treatment of delinquency: A review and proposal. Adolescence, 30 (117), 1-17.

Thornberry, G. (1987). Toward an interactional theory of delinquency. Criminology, 25, 863-891.

Tidwell, R., & Garrett, S. (1994). Youth at risk: In search of a definition. Journal of Counseling & Development, 72, 444-446.

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Running Head: SDD

Sexual Desire Disorders

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Introduction

This manuscript will define Sexual Desire Disorders (SDD), discuss the assessment of SDD's and discuss the treatment of SDD's. The two disorders listed in the SDD category are Hypoactive Sexual Desire Disorder (HSDD) (302.71) and Sexual Aversion Disorder (SAD) (302.79). The DSM-IV list the essential feature of Sexual Desire Disorders as being "the deficiency or absence of sexual fantasies and desire for sexual activity." (APA,1994)

Sexual Desire Disorder

The SDD's seems to be more common in females than in males. The prevalence of SDD is reported to be less than 5% for males and 20% for females (McCarthy, 1995). Segraves and Segraves (1991) report that SDD might be as high as 38% for men and 49% for women. The differential diagnosis for HSDD and SAD is that even though there are few if any fantasies and desires for sexual activity the individual with HSDD might participate in sexual activity and the individual with SAD will not. The HSDD individual will engage in sexual activity if pressured by their partner or to get other needs met such as, touching, intimacy, and security. "Low sexual desire may be global and encompass all forms of sexual expression or may be situational and limited to one partner or to a specific sexual activity (e.g. intercourse not masturbation)" (APA, 1994).

Individuals with HSDD might also have sexual arousal or orgasmic problems. Depression is also highly correlated with HSDD. The SAD individual will actively avoid genital sexual contact. They might report panic attacks, anxiety, fear, feelings of terror, faintness, nausea, dizziness and disgust when confronted with a sexual opportunity (APA,1994). Some SAD individuals experience general revulsion to all sexual stimuli (i.e. kissing and touching) and other SAD individuals report only revulsion to genital secretion or vaginal penetration. SAD individuals might use strategies like traveling, substance abuse, poor hygiene, or over involvement in work to avoid sexual situations.

Assessment

The assessment of Sexual Desire Disorders is very difficult. What is a sexual desire? Do men and women understand sexual desire the same way? Is the sexual desire a cognition (fantasy) or a behavior (action)? What is the etiology of the SDD? Is it biological, intrapsychic or interpersonal? These questions have been poorly understood and modestly researched. Spector, Carey and Stienburg (1996) are working on the Sexual Desire Inventory (SDI) to help to assess individuals with SDD. Their working definition of sexual desire is "interest in sexual activity." This is a cognitive construct not a behavioral one. The SDI is a self administered fourteen question inventory. The Inventory looks at

one's desire to be sexual with a partner (dyadic) and with oneself (solitary). One problem with this assessment could be that men and women might understand sexual desire differently. Regan and Berscheid (1996) state that men (50.9%) compared to women (28.7%) understand sexual desire with sexual fantasies and women (64.2%) compared to men (47.4%) understand sexual desire with behavioral or physiological events. If men and women understand sexual desires differently then do we need separate inventories for the different sexes? There are other tools that purport to measure sexual desire, the Derogatis Sexual Functioning Inventory (DSFI), the Sexual History Form (SHF) and the Sexual Desire Conflict Scale (SDCS). There appears to be problems with all the reported scales and inventories (Spector et al,1996). The DSM-IV states "because of a lack of normative age or gender related data on frequency or degree of sexual desire, the diagnosis must rely on clinical judgment based on the individuals characteristics, the interpersonal determinants, the life context and cultural setting" (APA, 1994). A clinician must be sure that a low desire in one partner is not reflecting an excessive need for sexual expression by the other partner. It is reported that the normal range of sexual behavior (not cognitive) is broad-from once every other week to four times a week. "Average intercourse for married couples is 1-2 times a week decreasing with age" (Lopiccolo & Friedman, 1989).

Treatment

Treating SDD's is as difficult as assessing them. SDD's are "one of the most difficult sexual problems to assess and treat (Kaplan, 1974). SDD's are the "most common complaint among couples seeking therapy" (Macphee, Johnson & Van Der Veer, 1995). Traditional sex therapy strategies are not powerful enough to treat desire problems. "Some suggest a post modern approach integrating Gestalt, Family of Origin and a Systems perspective" in dealing with sexual desire problems (Lopiccolo & Friedman, 1988). Regardless of the approach a counselor uses they need to be aware of certain information. In dealing with couples, most approaches attempt to increase the intimacy between them in hopes to increase their sexual interaction. In many cases the SDD in a couple might be a metaphor for the relationship (Atwood & Dershowitz, 1992). There also seems to be a difference between sexual desire (passion) and intimacy. Long term relationships can lose their passion over time but, the intimacy can grow between the couple (Lobitz & Lobitz, 1996). Knowing which format to use in marriage counseling is very important too. It is reported that the conjoint format is preferred over the group and individual format. The couples reported that they liked the shared responsibility of treatment and that more attention could be placed on the couples particular problems (Flammang & Wilson, 1992). Using co-therapists in a conjoint session

helps to bring out both partie's concerns and feelings about the SDD. Looking at what is happening in the relationship now is more important than going over past concerns. Working with psychological mechanisms like performance anxiety and anger at one's spouse is very important (Atwood & Dershowitz, 1992). Kaplan (1974) states that ..."when deep psychological stresses in a relationship are not resolved, therapy for overt sexual problems may not help." A systems approach to treatment would view the SDD as a symbol of the couples relationship. A counselor would need to look at power struggles, communication, competitiveness, sex roles and hostility.

Conclusion

Knowing that SDD's are one of the most common complaints for couples in therapy it is important for counselors to understand them and be able to treat them. The problem is that little definitive research exists on what they are. There also needs to be more research on how to diagnosis SDD's so we do not have to depend on the clinicians judgment. It does appear that the conjoint format is the most preferred way to approach couples in therapy who are dealing with SDD. More research on how to treat SDD's particularly with couples would be helpful.

References

American Psychiatric Association. (1994). Diagnostic and statiatical manual of mental disorders (4th ed.). Washington, D. C. : Author.

Atwood, J. D. , & Dershowitz, S. (1992). Constructing a sex and marital therapy frame: Ways to help couples deconstruct sexual problems. Journal of Sex and Marital Therapy, 22, 71-84.

Flammang, M. R. , & Wilson, G. L. (1992). Marital family formats: An analysis of acceptability rating with married spouses. Journal of Sex and Marital Therapy, 18, 159-172.

Kaplan, H. (1974). The new sex therapy. New York: Brunner/Mazed.

Lobitz, W. C. , & Lobitz, G. K. (1996). Resolving the sexual intimacy parodox. Journal of Sex and Therapy, 22, 71-84.

Lopiccolo, J. ,& Friedman, J. (1988). Broad spectrum treatment of low sexual desire. In S. Leiblum & R. Rosen (Ed.), Sexual desire disorder, (107-144). New York: Guilford.

Macphee, D. C., Johnson, S. M. & Van Der Veer, M. C. (1995). Low sexual desire in women: The effects of marital therapy. Journal of Sex and Marital therapy, 21,159-182.

McCarthy, B. W. (1995). Bridges to sexual desire. Journal of Sex Education and Therapy, 17, 55-58.

Regan, P. C. , Carey, M. P., & Steinberg, L. (1996). The sexual desire inventory: Belief about the state, goals, and objects of sexual desire. Journal of Sex and Marital Therapy, 22, 110-120.

Segraves, K. B., & Segraves, R. T. (1991). Hypoactive sexual desire disorder: Prevalence and comorbility in 906 subjects. Journal of Sex and Marital Therapy, 17, 55-58.

Spector, I. P. , Carey, M. P. , & Stienberg, L. (1996). The sexual desire inventory: Development, facture structure, and evidence of reliability. Journal of Sex and Marital Therapy, 22,175-190.

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Running head: Pmdd digest

Assessment and Treatment of Premenstrual Dysphoric Disorder

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Common complaints heard by both helping and health professionals who work with premenopausal women are those the fall into the diagnostic category of premenstrual syndrome and/or premenstrual dysphoric disorder. This is indeed a controversial diagnosis; however, because it is so widespread, it is important for mental health professionals to address the concerns of women who present with these symptoms. The main focus of this paper will be on the assessment of premenstrual dysphoric disorder, a term which is used interchangeably in the literature with premenstrual syndrome and late luteal phase dysphoric disorder and hereafter will be referred to in this paper as PMDD. Treatment implications for helping professionals who work with women also will be included. Additionally, a brief survey of the history of this topic and the controversy surrounding it also will be considered.

The idea that certain symptoms are associated with the premenstrual phase of the menstrual cycle has been acknowledged by physicians and in the general culture for little more that 60 years, and the idea of these symptoms comprising a clinical syndrome is only about 40 years old (Richardson, 1995). The etiology of premenstrual dysphoric disorder is at this time unspecified. After 20 years of intensive medical research, investigators are not much closer to finding a cause or treatment for PMDD (McFarlane & Williams, 1990). Hence, more researchers are offering treatment alternatives that focus on the psychological, behavioral, and social components of PMDD rather than viewing it from a strict medical perspective (McFarlane & Williams, 1990).

Many clinicians contend that the mild PMDD-like physical and emotional changes that occur in

women's ovulatory cycles are healthy and normal (Prior et al., 1987). A woman's lifestyle and psychological predisposition may intensify these normal changes and are experienced as PMDD. The controversy is that strong proponents of the PMDD-as-disease theories have been criticized for using the PMDD diagnosis as a means of exerting social control over women (McFarlane & Williams, 1990). Many researchers contend that PMDD is a problem in our culture because women are expected to maintain domestic tranquillity and refrain from expressing anger, thus making it a culture-bound syndrome (Prince, 1985). On the other hand, many feminists hail the recognition of this constellation of symptoms as a disorder, because PMDD has long been troublesome to a large percentage of the female population (Gise et al., 1990). Nevertheless, it is beyond question that in Western cultures there are shared attitudes and beliefs about the influence of the menstrual cycle upon women's experience which are held by both women and men (Richardson, 1990). The important point here is that despite the controversy, clients will continue to seek treatment for relief of premenstrual symptoms because these symptoms are interfering with their functioning, and mental health clinicians must likewise be prepared to contribute to the treatment of this disorder.

The diagnosis of PMDD is problematic because of the heterogeneous nature of the symptoms. In the first 30 years of research, over 150 different symptoms were said to vary with the menstrual cycle (Rubinow et al., 1984). Diagnoses have often been made not on the basis of specific symptoms, but on the timing of the symptoms. Thus, if a woman observes a cyclical change in one or more symptoms, she may wonder if she has PMDD. It is important for clinicians to remember that a

woman can experience some symptoms but not have PMDD according to the diagnostic criteria (McFarlane & Williams, 1990). One clinically useful description of PMDD has been formulated by Harrison, Rabkin, and Endicott (1985): a "constellation of mood, behavior, and/or physical symptoms which have a regular cyclical relationship to the luteal phase of the menstrual cycle, and are present in most (if not all) cycles, and remit by the end of menstrual flow with a symptom-free interval of at least one week" (p. 789). This description is further specified in the DSM-IV which specifies that the symptoms must be in most menstrual cycles in the last year, must be present in the last week of the luteal phase, remit in the first few days after the onset of the follicular phase, and be absent specifically the week postmenses (APA, 1994). The DSM-IV goes on to specify 11 different psychological, affective, and physical symptoms which include: 1) markedly depressed mood, 2) marked anxiety, 3) marked affective lability, 4) marked anger or irritability, 5) decreased interest in usual activities, 6) difficulty concentrating, 7) lethargy, 8) marked change in appetite, 9) hypersomnia or insomnia, 10) a subjective sense of being out of control, 11) other physical symptoms (APA, 1994). These symptoms are then followed by three qualifying conditions which include: 1) disturbance which seriously interferes with work or social functioning, 2) not just premenstrual exacerbation of other psychiatric problems, 3) the four previous criteria are confirmed by prospective daily self-ratings taken during at least two symptomatic cycles (APA, 1994). It is important for counselors to note that the first of these conditions, that the disturbance markedly interferes with work or school or with usual social functioning, is a qualifier for all DSM-IV diagnoses which should

always be kept in mind when making this or any diagnosis. (APA, 1994).

Assessment of PMDD has traditionally relied upon retrospective self-reports of premenstrual symptoms. More recent research studies have revealed that up to 50% of women self-diagnosed in retrospect with PMDD fail to demonstrate menstrually related changes when using prospective measures (Rubinow et al., 1984). Prospective measures refer to regular recording of physical, behavioral, and emotional symptoms as they occur over the entire menstrual cycle (Frank, Dixon & Grosz, 1993). There is growing evidence that prospective reports are the only acceptable way of demonstrating relationships among moods, behavioral changes, and the menstrual cycle (McFarlane & Williams, 1990). However, it should be noted that even prospective reports can be biased if a woman knows the purpose. This is because women presenting for PMDD research or treatment already know the menstrual interest of the researcher or clinician, so attempts must be made to diminish the effect of this knowledge and/or take this bias into consideration when evaluating daily reports (McFarlane & Williams, 1990). A major drawback to prospective reporting is client compliance. Since the reporting must be done on a daily basis and can be easily forgotten this may be an obstacle to diagnosis and treatment (Gise et al., 1990).

Rubinow, Roy-Byrne, Hoban, Gold, and Post (1984) have designed a prospective rating instrument that could be easily completed daily and that would accurately record the fluctuation of designated symptoms with respect to PMDD. This instrument provides a 100-mm visual analogue scale for twice daily self-rating of mood. The advantages of this method are simplicity, increased

compliance, ease of graphic presentation which allows the evaluation of severity and relationship to menstruation, and greater uniformity among studies of menstrually related syndromes (Rubinow et al., 1984). In preliminary application of this measure to 20 women with self-diagnosed PMDD only eight met the criteria for a menstrually related mood syndrome, and simple visual inspection of the graphs from the visual analogue scales was in most cases sufficient to confirm the diagnosis of PMDD (Rubinow et al., 1984).

The Minnesota Multiphasic Personality Inventory (MMPI) has also been used in evaluating women with PMDD. Women without PMDD had no clinically significant MMPI changes during their cycles (Chuong et al., 1988). However, women with PMDD had many statistically and clinically significant changes in MMPI response patterns over their cycles (Chuong et., 1988). Overall, the profile for PMDD women during the premenstrual phase was characterized by significant feelings of overall stress, tension, depression, anxiety, nervousness, over sensitivity, and social discomfort (Chuong et al., 1988). The MMPI data have also suggested the existence of two PMDD subgroups. The first which has cyclical variation from completely normal MMPI values during the follicular phase to significantly dysfunctional levels during the luteal phase, and the second which has psychologic stress and dysfunction throughout the cycle that are significantly greater than those in the women without PMDD, and are exacerbated during the premenstrual period (Chuong et al., 1988). Hence, different treatment approaches are likely to be needed for these two subgroups.

More structured assessment devices also are available. One of the most widely used is the

Premenstrual Assessment Form (Halbreich, Endicott, & Schacht, 1982). The Premenstrual Assessment Form (PAF) consists of three components: 1) general information about menstrual history and current cycles and health, 2) 95 descriptive items concerning mood, behavior, and physical condition, each rated on a 6-point continuum, 3) brief narrative description of the premenstrual period and how it differs from the symptom-free portion of the cycle. The PAF provides subscale scores along many differing dimensions of distress, and allows for differentiation of various subtypes of the disorder (Neirmeyer & Kosch, 1988).

As with diagnosis, the poorly defined etiology and heterogeneity of presenting symptoms associated with PMDD present challenges to developing a rational treatment approach. Because of the medical and psychological nature of the presenting problems, it is important that the treatment for PMDD be multimodal in nature. The inter disciplinary collaboration of counselor and physician is crucial for treatment to be successful. Additionally, since many aspects of the treatment of PMDD involve self-monitoring and self-assistance, the woman with PMDD may function as the most vital member of the treatment team. In fact, prospective assessment of premenstrual symptoms may help to reduce or eliminate the distress of PMDD. For example, 81% of women with prospectively confirmed PMDD reported that after a 2-month evaluation period their symptoms no longer interfered with their functioning (Gise et al., 1990).

Another relatively simple intervention also involves monitoring of PMDD symptoms. One study involving conjoint monitoring of the wife's PMDD symptoms by the husband found that not only

was marital satisfaction increased, but also many PMDD symptoms were alleviated in this situation (Frank, Dixon, & Grosz, 1993). The researchers in this study found that conjoint monitoring helped couples in discussing both individual and marital relationship needs and how to meet these goals. It is thought that the monitoring of premenstrual symptoms provides new information for both spouses, facilitating new, more empathic perspectives on the relationship (Frank, Dixon & Grosz, 1993).

Other treatment options relate to lifestyle issues such as diet, caffeine, nicotine, alcohol, exercise, or stress (Gise et al., 1990). Hence, every woman bothered by premenstrual symptoms can benefit from good health habits like getting adequate sleep, eating a healthy diet, exercising regularly and practicing stress-management techniques. In a prospective, controlled six month trial it was found that conditioning exercise decrease PMDD symptoms (Prior et al., 1987). While exercise is not routinely prescribed for women with PMDD, this study emphasizes that this very simple intervention may very well be good choice for clients with this condition. Many newer theories of PMDD purport that women's anger is not being taken seriously. This idea has some valid historical and cultural origins in that the Freudian idea of a woman being 'hysterical' is still very much at work today. Additionally, the cultural more that women fulfill many different roles like a proverbial 'super-woman' may exacerbate the anger and add stress to a woman's life. This stress and the anger that can accompany it may become difficult to manage when the physical and psychological symptoms associated with the premenstrual phase occur. Thus, it may be helpful for a woman to get counseling from someone who would accept her anger and be supportive as she confronts problems

in her life (McFarlane & Williams, 1990).

A medical treatment that has recently been introduced has been that of serotonin reuptake inhibitor antidepressants. These medications have been found to relieve the emotional and physical symptoms in about 60% of the women with severe PMDD (Brody, 1996). The medication is prescribed in doses smaller than those needed to treat depression, and it is taken only a week or two before the onset of menses (Brody, 1996). It is important to remember that though the medications do help, one should not think that simply taking a pill will make this better. PMDD sufferers must still pay attention to lifestyle variables.

Mental health practitioners can play an increasingly important role in the assessment and treatment of PMDD. Particularly relevant are interventions directed at helping the client with self-monitoring, lifestyle choices, and stress reduction which can help alleviate many symptoms associated with this disorder. Family or couples counseling may also be helpful in assisting the client and her family to further understand the nature of PMDD and how they can better deal with the symptoms on a systemic level.

REFERENCES

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Brody, J., (1996, September 15). With new treatments, PMS need not be the worry it was just decades ago. The New York Times, p. D14.

Chuong, C., Colligan, R., Coulam, C., Bergstrah, E., (1988). The MMPI as an aid in evaluating patients with premenstrual syndrome. Psychomatics 29, 197-202.

Frank, B., Dixon, D., & Grosz, H. (1993). Conjoint monitoring of symptoms of premenstrual syndrome: Impact on marital satisfaction. Journal of Counseling Psychology 40, 109-114.

Gise, L., Lebovitz, A., Paddison, P., & Strain, J. (1990). Issues in the identification of premenstrual syndromes. Journal of Nervous and Mental Disease 178, 228-233.

Halbreich, U., Endicott, J., & Schacht, S. (1982). Premenstrual syndromes: A new instrument for their assessment. Journal of Psychiatric Treatment and Evaluation 4, 161-164.

Harrison, W., Rabkin, J., & Endicott, J. (1985). Psychiatric evaluation of premenstrual changes. Psychomatics 26, 789-799.

McFarlane, J., & Williams, T. (1990). The enigma of premenstrual syndrome. Canadian Journal of Psychology 31, 95-108.

Neirmeyer, G., & Kosch, S. (1988). An overview of assessment and treatment of premenstrual syndrome. Journal of Counseling and Development 66, 397-399.

Prince, R. (1985). The concept of culture bound syndromes: Anorexia nervosa and brain-lag. Social Science and Medicine 21, 197-204.

Prior, J., Vigna, Y., Sciaretta, D., Alojado, N., Schulzer, M. (1987). Conditioning exercise decreases premenstrual symptoms: A prospective, controlled six-month trial. Fertility and Sterility 47, 402-408.

Richardson, J. (1995). The premenstrual syndrome: A brief history. Social Science and Medicine 41, 761-767.

Rubinow, D., Roy-Byrne, P., Hoban, C., Gold, P., Post, R. (1984). Prospective assessment of menstrually related mood disorder. American Journal of Psychiatry 141, 684-686.

Gender Differences in the Assessment of Schizophrenia

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INTRODUCTION

Research on gender differences in schizophrenia has revealed much about the nature of this disorder and the variable manner in which it affects men and women variably. Studies over the last two decades have revealed differences in the prevalence rate, age of onset, premorbid symptoms, coping and social skills, cognitive performance, treatment response and outcome. Despite the advances in research, the etiology of schizophrenia remains unclear.

Schizophrenia was first described by Kraepelin in late 19th century as a functional psychosis found in men and was further studied by Eugen Bleuler who was to coin the term "schizophrenia." Bleuler described schizophrenia as an ailment which is accompanied by a loosening of reality (Carson and Sainslow, 1993).

This paper will address gender differences in schizophrenia that are related to age of onset, treatment response and course of illness. These factors are critical in the assessment and treatment of those afflicted with schizophrenia.

AGE OF ONSET

Numerous studies have consistently reported an earlier onset of schizophrenia in male patients than in female patients, (Henry, 1985). These differences in the age of onset of schizophrenia among men and women have been consistently replicated in research. The mean onset of illness as reported by Bleuler in 1950 was 3.7 years earlier for males (Carson and Sainslow, 1993). However, more recent studies have not only replicated this finding but have reported onset differences ranging from 3.7 years to 5 years. A study conducted by Loranger (1984) investigated three different variables involved in the onset of schizophrenia, first treatment,

first hospitalization and immediate family's first awareness of symptoms. Loranger was able to conclude a mean age of onset that was 5 years earlier in males than in females. Gorwood *et al.* (1995) were able to replicate this finding in a study that revealed a mean onset of 27.8 years in males and 31.5 years in females.

Various explanations and hypotheses exist for the later onset of schizophrenia in females. Neuroendocrine mediation of the disease among women is thought to delay the onset of schizophrenia. Since estrogen may have a protective effect in females (Seeman, 1985), it may play a neuroleptic-like role in the disease process of schizophrenia. Neuroleptics are dopamine antagonists and represent a class of drugs which are commonly used in the control of psychotic symptoms (e.g., chlorpromazine, fluphenazine, haloperidol). The dopamine hypothesis for schizophrenia is well established and suggests that schizophrenia is a product of excessive activity in the dopaminergic pathway. The neuroleptic-like effect of estrogen may serve to delay the onset of schizophrenia in women. Moreover, women are likely to be protected against schizophrenia during periods of pregnancy. This is true for premenopausal women since prevalence rates for schizophrenia among postmenopausal women rise significantly.

Other factors are also hypothesized to contribute to the delay in the onset of schizophrenia in women. Premorbid functioning is an important variable in the onset of schizophrenia. Among married women, the onset of the illness is delayed by an average of 6.3 years compared to men (Loranger, 1984). A study conducted by Andia *et al.* (1995) elucidates the point that women have better premorbid function which could delay onset of schizophrenia. The study revealed that women functioned better socially than men as represented by being married, employed, and living

independently. These differences not only influence the age of onset but also influence subsequent treatment and outcome.

Further studies have confirmed that men have worse premorbid adjustment than women. A study done in a psychiatric hospital in Finland revealed that 40% of the men had never had social relationships with members of the opposite sex, as compared with 16% of the women on first admission (Salokangas, 1983). Moreover, men had more troubled histories as evidenced by asocial behavior, running away from home, truancy and pilfering. Before first admissions, men had shown difficulty in work adjustment, frequent job changes, quarrels with fellow-workers and dismissals.

Hormonal factors in puberty may also be possible triggers for the early onset in males. The surge in androgens in males possibly heightens libido and aggression that precipitates the onset of schizophrenia (Rose, 1974). Higher socio-economic expectations in men exerted by societal pressures may hasten the appearance of schizophrenia in those who are predisposed (Henry, 1985).

Clinicians who are aware of these factors can assess and prescribe interventions according to the needs of individuals with schizophrenia. Males are likely to need assistance with relationships and developing social skills to interact more effectively. In addition, males may require aid in seeking and maintaining employment. Clinicians need to address the psychosocial histories, including significant relationships of men and women during assessment. Moreover, clinicians can consider the repertoire of adaptive and learning skills in individuals and integrate interventions to address this aspect. There is little clinicians can do to facilitate interventions before the onset of schizophrenia to improve premorbid function, since individuals will seek out

treatment only when confronted with symptoms that require the attention of a professional. Clinicians can effectively intervene after diagnosis to ensure that men are aware of prognostic implications and are equipped to deal with the ongoing implications of schizophrenia. In sum, psychosocial and premorbid function influence age of onset in males and females. Women have an advantage in terms of onset of illness being delayed and these factors further influence treatment and course of illness.

Treatment and Prognosis

Treatment and course of illness are on a continuum from premorbid function which influences age of onset. Studies have confirmed that premenopausal women respond to lower doses of neuroleptics. Andia *et al.* (1995) report that women were maintained on significantly lower doses of neuroleptic medications than men and were able to maintain greater levels of performance and function as indicated by being married, employed and living independently. Salokangas (1983) conducted follow-ups on patients and found that men were admitted more frequently and for more prolonged periods than women. Further follow-ups indicated a difference between the sexes in clinical status: recovered and symptom-free cases accounted for almost one-third of the women, but less than one-fifth of men. Men also needed social assistance more often than women.

Shtasel *et al.* (1992) studied sex differences in the level of functioning and ascertained data consistent with the prevailing view that women with schizophrenia have overall better functioning and quality of life than men, including a sense of involvement and social functioning. Other studies indicate that women survive longer than men without the need for rehospitalization

(Hogarty *et al.*, 1974). Women also tend to cope better with schizophrenia than men. A study of 200 chronic schizophrenics revealed that, compared to men, women demonstrated adaptive learning to a greater degree which included following the advice of health care providers, applying techniques learned in therapy or behaving like people they thought were normal. In contrast, men tended to use tactics which distracted them from the disturbing pattern of physiological stimulation such as listening to music and playing sports (Carr and Katsikitis, 1987)

Based on the foregoing, Loranger (1984) postulated a less severe form of schizophrenia prevalent in female patients with delayed onset being a possible manifestation. Thus, it may appear that women have an advantage in the disease process of schizophrenia. However, it is worth noting that lower prevalence is a characteristic only among premenopausal women. The neuroleptic actions of estrogen are not as pronounced in postmenopausal women. Consequently, compared to men, a disproportionately greater number of older women are diagnosed with paraphrenia or late onset schizophrenia. Moreover, postmenopausal women require higher doses of neuroleptic medications than men (Seeman, 1985).

The foregoing considerations underscore the implications for differential assessment: the clinician needs to be aware of the different needs of males and females diagnosed with schizophrenia. It is possible that men with schizophrenia will need more social and economic support. Males coming in for assessment are likely to be younger than females and a greater number of males will seek out support. Clinicians should be aware of age considerations in assessment of schizophrenia among males and females and exercise caution when presented with a premenopausal woman without a family history of schizophrenia. However, it is important also to

acknowledge that a less severe form of schizophrenia among women, as postulated by Loranger, could result in an alternate diagnosis.

Concluding Remarks

Research clearly indicates gender differences among men and women with schizophrenia in the age of onset and prognosis. Women have better premorbid function and coping skills that may be due to a later onset of the illness which, in turn, allows women to develop more effective skills to cope with the disease. Men have relatively poor premorbid function which may influence prognosis. Research suggests that the adolescent and early adult years are perhaps more stressful for male patients possibly because there is more pressure on young men to achieve social and financial independence. Aggression is likely to play a role in the manifestation of schizophrenia. This trait that clearly distinguishes men from women and it is possible that those with aggressive tendencies will manifest the illness at an earlier stage. Finally, compared to men, women tend to have some degree of protection from schizophrenia due to the neuroleptic effects of estrogen which subside after menopause.

The onset and course of schizophrenia are mediated by environmental, genetic and social forces and gender seems to play a role in the symptom presentation and prognosis of patients with schizophrenia. Much more exhaustive research is needed to understand the precise interplay of the varying forces which contribute to this illness. Only then can interventions address these factors and allow men and women with schizophrenia to function more effectively.

References

Andia, A.M., Zisook, S., Heaton, R.K., Hesselink, J., Jernigan, T., Kuck, J., Moranville, J., Braff, D. J. (1995). Gender differences in schizophrenia. Journal of Nervous and Mental Disorders., 183. 522-528.

Carr, V., Katsikitis, M. (1987). Illness behavior and schizophrenia. Psychol. Med. 5 163-170.

Carson, R. C., Sainslow, C.A. (1994) in Sutker, P. B. & Adams, H. E. Comprehensive Handbook of Psychopathology. New York: Plenum Press.

Gorwood, P., Leboyer, M., Jay, M., Payan, C., Feingold, J. (1995). Gender and age at onset in schizophrenia: impact of family history. American Journal of Psychiatry, 152, 208-212.

Henry, P. F. (1985). Schizophrenia: sex differences. Canadian Journal of Psychiatry, 30, 319-322.

Hogarty, G. E., Goldberg, S. C. Schooler, N. R. (1984). Drugs and sociotherapy in the aftercare of schizophrenic patients. Archives of General Psychiatry, 31, 609-618.

Loranger, A. W. (1984). Sex difference in age at onset of schizophrenia. Archives of General Psychiatry, 41, 157-161.

Rose, R. M. (1974). Testosterone and aggression in man. Psychosomatic Medicine, 36, 467-468.

Salokangas, R. K. R. (1983). Prognostic implications of the sex of schizophrenic patients. British Journal of Psychiatry, 142, 145-151.

Seeman, M. V. (1985). Sex and schizophrenia. Canadian Journal of Psychiatry, 30, 313-315

Shtasel, D. L., Gur, R. E., Gallacher, F., Heimberg, C., Gur, R. C. (1992). Gender differences in the clinical expression of schizophrenia. Schizophrenia Research, 7, 225-231.

Running head: EFFECTS OF ADHD

Assessing the Effects of ADHD on the Family

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Assessing the Effects of ADHD on the Family

Attention-Deficit Hyperactivity Disorder is a diagnosis many clinicians are familiar with whether they work in community mental health, family counseling centers, or schools. The majority of these clinicians are also familiar with the signs, symptoms, and criteria that a child has to meet to receive this diagnosis. However, assessing only the individual child and his or her behaviors is like getting only half the story. It is also necessary to spend time with parents and siblings to assess what is going on within the family system.

Within families of an ADHD child, typical themes occur that clinicians need to be aware of when making assessments. In 1994, Bernier and Siegel indicated that a review of the literature suggests there are four main themes that occur in these families: family instability and marital disruption, high levels of parental stress, conflict-laden parent child interactions, and maternal depression.

In this paper, the above themes will be addressed so that clinicians will have an idea of what to look for when they are working with these families. A list of assessment instruments that may be useful with each theme also will be included. This list will not include a detailed description of each instrument. Rather, its purpose is to give clinicians an idea of where to start. Within this paper, the ongoing debate of whether these family themes are a result of having an ADHD child or having

an ADHD child is the result of these themes will not be addressed. Rather, the focus of this paper is how to assess the themes that the literature suggests exist.

One theme of families with ADHD children is family instability and marital disruption (Bernier & Siegel, 1994). In an eight year follow-up study, Barkley et al. (1990) found that parents of ADHD children are three times as likely to separate or divorce when compared to parents of average children. In 1990, Fischer reports that these parents report marital discord more than other parents. This may be partly related to the idea that "many of the stressors that affect families without hyperactive children, such as life-cycle issues.....may exacerbate feelings of helplessness, guilt, anxiety, and depression of parents who are not effectively coping with their hyperactive child" (Coker & Thyer, 1990). In other words, changes in family or marriage life that other couples pass through fairly easily are very difficult for these couples due to the amount of time and energy that is already being expended dealing with a child. Marital and family relations may take a back seat to child rearing. This kind of family can be structurally conceptualized as a child focused family structure (Flynn, 1985). Within this family, the most important function is child rearing with excessive concern for the dysfunctional child. This can lead to avoidance of spousal conflicts and issues. It can also lead to one parent being enmeshed with the child while the other is disengaged (Flynn, 1985).

The first step to assessing this in families is to be aware

of it and ask some questions about how things are going for the parents. This questioning can include things about their jobs, recreation, time alone, etc. There are also some inventories that may prove to be helpful. Some of these that have been used or noted in earlier studies are The Family Environment Scale, FACES, and The Locke-Wallace Marital Adjustment Test (Barkley et al., 1992; Flynn, 1985; Lewis, 1992; Rostain, Power, Atkins, 1993). Other instruments that may also be used are The Marital Satisfaction Inventory and The Marriage Counseling Report.

Success in this area requires some skills beyond assessment. It is important to join thoroughly with the family and explore the presenting problem fully before moving into assessing family stability or marital relations. If this is done too quickly, parents can easily become offended with thoughts of "I came here for my child, not to work on my marriage." It is also important that parents do not feel as if their marital and family relations are being blamed for the child's behaviors. In either of the above cases, drop out from treatment may be likely.

A second theme to assess for in these families is high levels of parental stress (Bernier & Siegel, 1994). In many cases, these families are experiencing stressors and pressures more than those that occur in the normal developmental process (Schwiebert, Sealander, & Tollerud, 1995). In 1990, Fischer indicated that parents of ADHD children report high stress more than other parents. This is partly related to the quote cited above that indicates that life cycle issues are even more

stressful for these already heavily laden parents (Coker & Thyer, 1990). This is also related to high levels of tension within the home and continual existence of something to deal with (Coker & Thyer, 1990). These parents sometimes feel as if they are being hit from all sides with complaining phone calls from schools, church, day care, friend's parents, and relatives so that sources of external stress are numerous and high (Bernier & Siegel, 1994). This can lead to withdrawal from social activities which can in turn lead to social isolation that serves to exacerbate already high levels of stress. It is also possible that high stress levels can play a role in marital disruption.

Again, one way to assess for this theme is to simply be aware of it and ask questions about stress and tension in the home. One standardized instrument that may be of particular help is The Parenting Stress Index (Rostain, Power, & Atkins, 1993).

A third theme often seen in these families is conflict laden parent-child interactions (Bernier & Siegel, 1994). In 1991, Frick and Lahey indicated that a review of the literature suggests a number of dysfunctional interaction patterns exist between ADHD children and their parents with these parents being more controlling, negative, and directive and less responsive and rewarding than parents of control groups. This follows the old adage of "let a sleeping dog lie." These parents often spend so much time attending to the child's misbehaviors that the child is ignored when behaving appropriately. This in turn can serve to reinforce negative behaviors and the child may

quickly learn they do not get as much attention when they are well behaved (Danforth, Barkley, & Stokes, 1991).

In 1981, Lorber and Patterson point to the existence of patterns of interactions between ADHD children and their parents. They describe reciprocal interaction as the child escalating aversive behavior in response to parental punishment and a decrease in positive interactions over time. In 1982, Patterson describes coercive interaction/escalation as when the parent and child compete for control. The parent will issue a command to a behavior, to which the child escalates his aversive behavior, to which the parent escalates his aversive response and so on. At some point, the parent or child will grow tired and comply or withdraw by which the other partner in this circular dance will be reinforced for his or her aversive behavior/response. Behaviors become escalatory in that the child may remember a temper tantrum worked last time so he or she will start the interaction with a tantrum rather than with whining behaviors. The parent's responses become escalatory in that he or she may remember that yelling worked last and will begin with yelling rather than with speaking a command (Newby, Fischer, & Roman, 1991).

Assessment for this theme can be done through live observation. This can be done through one way mirrors or in your office. Clinicians can give a family a task or conflict to work on and observe their interactions (Flynn, 1985). There are several coding systems which allow for recording interactions. These include The Parent-Adolescent Interaction

Coding System, Family Interaction Coding System, and Family Process Code (Barkley et al., 1992; & Danforth, Barkley, & Stokes, 1991). However, it is not necessary to use a formal coding system as these behaviors and interaction processes can often be seen by just simply sitting back and observing.

A final theme that needs to be assessed within these families is maternal depression (Bernier & Siegel, 1994). Bernier and Siegel (1994) cite numerous studies that show mothers of ADHD children are more likely to be depressed than mothers of control groups. These mothers also have lower levels of parenting self-esteem, more social isolation, and more self blame (Mash & Johnston, 1983). All of this becomes even more important due to the finding that parents who are psychologically distressed or depressed report more problem behaviors than parents who are not (Edwards, 1995).

To assess for maternal depression in these families, a clinician first of all needs to know to look for it. Questions can be asked regarding any symptoms parents are currently experiencing. There are also numerous instruments that can be used to assess for depression. Among these that have been used for this purpose is The Beck Depression Inventory (Barkley et al., 1992). The Beck Hopelessness Scale may also be of use in assessing this theme.

When working with ADHD children it is important to assess for things other than the child's behavior. Themes to be assessed include family instability and marital disruption, high parental stress, conflict laden parent child interactions,

and maternal depression. Assessing for these things is important because it gives a much clearer picture of the child's daily environment. It also gives a clinician an idea of what things need to be addressed during treatment. Without a thorough and complete assessment of a child's entire family system, issues and themes that play an important part in successful treatment outcome may be overlooked.

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References

Barkley, R. A., Fischer, M., Edelbrock, C. S., & Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria, I: An 8-year prospective follow-up study. Journal of the American Academy of Child and Adolescent Psychiatry, 29, 546-557.

Barkley, R. A., Guevremont, D. C., Anastopoulos, A. D., & Fletcher, K. E. (1992). A comparison of three family therapy programs for treating family conflict in adolescents with attention-deficit hyperactivity disorder. Journal of Consulting and Clinical Psychology, 60, 450-462.

Bernier, J. C., & Siegel, D. H. (1994). Attention-deficit hyperactivity disorder: A family and ecological systems perspective. Families in Society, 40, 142-150.

Coker, K. H., & Thyer, B. A. (1990). School and family based treatment of children with attention-deficit hyperactivity disorders. Families in Society, 71, 276-282.

Danforth, J. S., Barkley, R. A., & Stokes, T. F. (1991). Observations of parent-child interactions with hyperactive children: Research and clinical implications. Clinical Psychology Review, 11, 703-727.

Edwards, M. C., Schulz, E. G., & Long, N. (1995). The role of the family in the assessment of attention-deficit hyperactivity disorder. Clinical Psychology Review, 15, 375-394.

Fischer, M. (1990). Parenting stress and the child with attention-deficit hyperactivity disorder. Journal of Clinical Child Psychology, 19, 337-346.

Flynn, R. J. (1985). Structural family therapy of a family with a hyperactive child: A single subject investigation. Ann Arbor, MI: University Microfilms International.

Frick, P. J., & Lahey, B. B. (1991). The nature and characteristics of attention-deficit hyperactivity disorder. School Psychology Review, 20, 163-173.

Lewis, K. (1992). Family functioning as perceived by parents of boys with attention deficit disorder. Issues in Mental Health Nursing, 13, 369-386.

Lorber, R., & Patterson, G. R. (1981). The aggressive child: A concomitant of a coercive system. In J. P. Vincent (Ed.), Advances in family intervention, assessment and theory: An annual compilation of research (pp. 47-87). Greenwich CT: JAI Press.

Mash, E. J., & Johnston, C. (1983). Parental perceptions of child behavior problems, parenting self-esteem, and mothers' reported stress in younger and older hyperactive and normal children. Journal of Consulting and Clinical Psychology, 51, 68-99.

Newby, R. F., Fischer, M., & Roman, M. A. (1991). Parent training for families of children with ADHD. School Psychology Review, 20, 252-265.

Patterson, G. R. (1982). A social learning approach to family interaction. Vol. 3. Coercive family process. Eugene, OR: Castalia.

Rostain, A. L., Power, T. J., Atkins, M. S. (1993). Assessing parents' willingness to pursue treatment for children

with attention-deficit hyperactivity disorder. Journal of American Academy of Child and Adolescent Psychiatry, 32, 175-181.

Schwiebert, V. J., Sealander, K. A., & Tollerud, T. R. (1995). Attention-deficit hyperactivity disorder: An overview for school counselors. Elementary School Guidance and Counseling, 29, 249-259.

Running head: ASSESSMENT OF ADOLESCENTS IN STEPFAMILIES

Assessment of Adolescents in Stepfamilies: Using a Developmental Framework

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Assessment of Adolescents in Stepfamilies: Using a Developmental Framework

Many adolescents are currently living in stepfamilies due to the high rates of divorce and remarriage in the United States (Kelly, 1992). Their families include parents, stepparents, siblings, stepsiblings, and others; they may reside in more than one household. For these adolescents, the multiple losses, transitions, and stresses of parental divorce and remarriage place them at increased risk for problem development (Bray & Harvey, 1995). Assessment of the adolescent in the context of his or her stepfamily is critical to a real understanding of the problems he/she is experiencing and to engaging the adolescent and family in appropriate treatment.

The Stepfamily Context

The inherent complexity of the structure and dynamics of the stepfamily system are formidable challenges to family integration and cohesion (Bray & Berger, 1993). Although it is beyond the scope of this paper to describe these in depth, the following list indicates aspects of stepfamily functioning which can be problematic (Pasley & Dollahite, 1995):

*Stepfamilies are formed out of pain and loss
*Stepfamily members may bring with them unresolved divorce issues
*Parent-child relationships predate the couple relationship
*There is a lack of shared family history
*There is little consensus on the roles, rules, and routines within the stepfamily

These aspects of stepfamily functioning complicate the normal developmental processes of adolescence. For these and other reasons, an adolescent may respond with negative and/or destructive behaviors to the remarriage of his or her custodial parent.

Developmental Framework

Using a developmental framework to guide the assessment of adolescent problems and their relationship to the stepfamily context normalizes the high levels of stress and conflict experienced by the family (Visher & Visher, 1996). Where possible, the developmental assessment distinguishes stepfamily concerns from the difficulties experienced by adolescents in any family. While accounting for individual and environmental factors, the goal of the assessment is to

identify which stepfamily dynamics contribute to adolescent's problems.

After providing a brief overview of the impact of stepfamily functioning on adolescent development, some guidelines will be offered for using specific assessment methods with the adolescent and stepfamily. Key developmental issues to explore in assessment include individuation and autonomy, the establishment of intimacy, and the exploration of sexuality.

The process of individuation balances a healthy detachment from the family with positive interactions with parent(s) and stepparent(s). Frequently, the adolescent need for autonomy is at odds with the newly formed stepfamily's desire to build close relationships through family activities (Visher & Visher, 1996). The adolescent who has obtained "adult" privileges and freedom during a single-parent transition will consider the stepfamily's overtures for closeness as an infringement. In addition, a real or perceived loss of power and position in the family adds to feelings of resentment. Assessment of ongoing conflict between custodial and non-residential parents can reveal underlying causes for power struggles with the adolescent (Bray & Harvey, 1995). Problematic coalitions between parent-adolescent need to be examined as well.

Supportive relationships with parents/stepparents provide the foundation for adolescent efforts to establish intimacy with others. Affirmation from the opposite sex-parent and identification with the same sex-parent are important factors in development. When the adolescent has a minimal sense of belonging to the family group, assessment looks for emotional cut-offs from one or both parents (Pasley & Dollahite, 1995). On the other hand, assessment gauges the amount of pressure on the adolescent to form stepfamily attachments too quickly.

An adolescent attempting to understand his or her sexuality may be distressed by the remarried couple's romantic/sexual behaviors. Sexuality and intimacy issues become blurred in stepfamilies due to the ambiguous roles of the stepparent in relation to stepchildren and the lack of biological connection. For the adolescent and the opposite-sex stepparent, developing sexuality can be threatening. The adolescent and/or the stepparent may use negative behavior to prevent feelings

of attraction and closeness from developing. Because there is a higher incidence of sexual abuse for stepchildren either by a stepfather or steprelative (Bray & Harvey, 1995), assessment should incorporate questions about sexual attitudes and behaviors for all family members.

Although these are not the only developmental issues which can be problematic in stepfamilies, they are useful "windows" on the quality of adolescent-parent/stepparent interactions. By using a developmental framework for assessment, the counselor makes connections between the presenting problem and seemingly unrelated difficulties of the stepfamily. This allows the assessment to become an educational intervention regarding stepfamily issues and changes the focus on a negatively targeted adolescent.

Assessment Issues and Methods

The mental health professional who works with adolescents and their stepfamilies has no comprehensive guide for conducting assessment (Lawton & Sanders, 1994). There is agreement in research and clinical data on the need to utilize multiple measures and obtain multiple perspectives in family assessment (Green & Vosler, 1992). The clinical interview is a significant part of the assessment. More suggestions are offered for using the clinical interview with adolescents and stepfamilies than for using observation/rating techniques, self-report measures, or other instruments (Papernow, 1995).

Some instruments specifically designed for stepfamilies are being used in research and clinical work, but these need further evaluation and testing on larger sample populations. Standardized measures designed for use with individuals or intact families may have limited reliability and validity when used with stepfamilies (Fine & Kurdek, 1995). A primary concern is that assessment should not be based on a deficit model of comparison between stepfamilies and the nuclear family (Visher & Visher, 1996).

Stepfamilies requesting therapy are often in crisis. The family members who come for assessment may appear angry, depressed, or anxious. They may seek help for an adolescent experiencing problems with substance abuse, conduct disorder, poor school performance, or

at-risk sexual behaviors (Bray & Harvey, 1995). In the initial session, stepfamily members are likely to be highly emotional, making potentially damaging statements about each other. For these reasons, it is preferable to begin the assessment with various stepfamily subsystems (parent/stepparent) and individuals rather than the entire stepfamily (Papernow, 1995).

The clinical interview seeks thorough coverage of stepfamily history, including the adolescent's age and reaction to family transitions (divorce, dating, remarriage, moves) and of the presenting problem (Pasley & Dollahite, 1996). The emerging picture of stepfamily structure indicates who resides in the household, the number and quality of relationships within the stepfamily, custody/visitation issues, and contact with the non-residential parent. Questions about family functioning evaluate discipline and rules, family communication, and unrealistic expectations about relationships (Papernow, 1995). Both parent and stepparent are given opportunities to respond so that assessment can probe the effectiveness of the parental subsystem.

The adolescent offers information in a separate interview. It is critical that the adolescent feel invested in assessment process. Lack of rapport and sensitivity to the adolescent's point of view negates the potential for successful diagnosis and intervention within the stepfamily system (Young, Anderson, & Steinbrecher, 1995). Relating to the adolescent in a personal way is more effective than assuming a professionally neutral stance as an "evaluator."

Where indicated by the clinical interview, screening instruments for specific problems such as depression, anxiety, eating disorders, substance abuse may be given to either adolescent or the adults (Lawton & Sanders, 1994). Indicators of suicidal thinking or abuse in the family preempt other concerns. Health-related issues may be identified during the clinical interview.

Assessment of other aspects of behavior and adjustment can be measured with a variety of instruments. Measures in the following areas are most often suggested by current literature: individual perceptions of overall family functioning, marital satisfaction, beliefs and expectations about stepfamily relationships, and parent/stepparent agreement on rules and discipline. Other

areas suggested for evaluation are levels of family stress, level of co-parental interaction between parent and non-residential parent, and family problem solving skills.

Instruments measuring overall family functioning include scales for flexibility, cohesion, structure, and other aspects of family interactions. The Family Assessment Device, Self-report Family Instrument, Family Awareness Scale, and Family Adaptability and Cohesion Scales have been used as instruments in stepfamily research and clinical practice (Bray & Berger, 1993; Kelly, 1992; Lawton & Sanders, 1994). The Dyadic Adjustment Scale is mentioned as a proven measure of marital adjustment (Bray & Berger, 1993). Expectations and beliefs about relationships in the stepfamily can be measured using the Family Beliefs Inventory, the Parent Adolescent Communication Scale, and the Relationship Beliefs Inventory (Fine & Kurdek, 1995).

The primary consideration in using any of the standardized measures listed above is sensitivity to interpretation of results. Because these instruments are based on assessment of intact families, some scales may be inadequate measures of complex stepfamily interactions. Another key factor is to look for convergence of information provided by these instruments rather than distinct components or individual results. The multiple perspectives of stepfamily members (adolescent and adult) need validation by the therapist. The assessment process can model a flexible and creative approach greatly appreciated by the stepfamily.

Current assessment methods offer a beginning point for evaluating stepfamily interactions which impact adolescent development. Because a developmental framework for assessment normalizes the experiences of the adolescent and the stepfamily while indicating areas of family functioning which can be improved, it can lead to successful diagnosis and intervention. There needs to be a greater emphasis on designing assessment methods which give consideration to the unique aspects of stepfamily life and which identify the strengths and capabilities of healthy stepfamilies (Pasley, Rhoden, Visher, & Visher, 1996).

References

Bray, J. H. & Berger, S. H.(1993). Developmental issues in stepfamilies research project: Family relationships and parent-child interactions. Journal of Family Psychology, 7, 76-90.

Bray, J. H. & Harvey, D. M. (1995). Adolescents in stepfamilies: Developmental family interventions. Psychotherapy, 32, 122-130.

Fine, M. A. & Kurdek, L. A. (1995). The nature and assessment of cognitions in stepfamilies. In D. K. Huntley (Ed.), Understanding stepfamilies: Implications for assessment and treatment (pp. 113-126). Alexandria, VA: American Counseling Association.

Green, R. G. & Vosler, N. R.. (1992). Issues in the assessment of family practice: An empirical study. Journal of Social Service Research, 15, 1-19.

Kelly, P. (1992). Healthy Stepfamily Functioning. Families in Society, 73, 579-587.

Lawton, J. M. & Sanders, M. R. (1994). Designing effective behavioral family interventions for stepfamilies. Clinical Psychology Review, 14, 463-496.

Papernow, P. L. (1995). What's going on here: Separating (and weaving together) step and clinical issues in remarried families. In D. K. Huntley (Ed.), Understanding stepfamilies: Implications for assessment and treatment (pp.3-24). Alexandria, VA: American Counseling Association.

Pasley, K. & Dollahite, D. (1995). The nine Rs of stepparenting adolescents: Research based recommendations for clinicians. In D. K. Huntley (Ed.), Understanding stepfamilies: Implications for assessment and treatment (pp. 87-100). Alexandria, VA: American Counseling Association.

Pasley, K.; Rhoden, L.; Visher, E. B. & Visher J. S. (1996). Successful stepfamily therapy: Clients' perspectives. Journal of Marital and Family Therapy, 22, 343-357.

Visher, E.B. & Visher, J. S. (1996). Therapy with stepfamilies. New York: Brunner/Mazel

Young, I. L., Anderson, C. & Steinbrecher, A. (1995). Unmasking the phantom: Creative Assessment of the adolescent. Psychotherapy, 32, 34-38.

Running head: PREMARITAL ASSESSMENT

Assessment in Premarital Counseling and Premarital Preparation Programs

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Overview

Traditionally, premarital counseling has not been considered a necessity by couples wishing to marry. In fact, "only about one-third of couples received even 1-2 hours of formal training" (Silliman & Schumm, 1989, p. 199). For couples who desire to be married in a church, however, premarital counseling has been and still may be required by the officiating clergy member. As of 1989, the clergy provided roughly 80% of all premarital counseling (Silliman & Schumm). Professional marital and sex therapists provided the balance.

Research in the last decade indicated that many high school and college students were both interested in and open to the idea of receiving premarital preparation training (Silliman & Schumm, 1989). Shack (1989) noted that "realistic sensitivity to the divorce rate statistics, the current tendency to have experts consult on all major decisions, and the caution taken by religious institutions in supporting marital decisions" (p. 122) fueled an increase in the trend of engaged couples seeking premarital counseling.

According to Shack (1989), the desire to improve an already strong relationship, an assessment of the relationship's strengths and weaknesses, and experiencing conflict in the relationship during the engagement were the factors most likely to influence a couple's decision to pursue premarital counseling. Some of the major benefits of premarital counseling, highlighted by Shack, were the brief duration of counseling and the limited

number of issues to assess and discuss. Additional benefits include the preventative nature of premarital counseling, the positive focus of the counseling, and the optimistic outlook for the marriage of couples who engage in premarital preparation.

Assessment Instruments

Most premarital counseling and premarital preparation programs utilize some form of assessment of the couple's relationship. This assessment may be formal, as in the use of standardized assessment instruments, or informal, where the counselor and the couple discuss issues of particular concern and develop a program to address those issues. Two commonly used formal assessment tools are Premarital Personal and Relationship Evaluation (PREPARE) and Facilitating Open Couple Communication, Understanding, and Study (FOCCUS).

PREPARE contains 125 items which measure strengths and weaknesses of 11 relationship areas using a 5 point Likert-type scale ranging from strongly agree to strongly disagree (Larsen & Olson, 1989). The 11 relationship areas include: (a) realistic expectations, (b) personality issues, (c) communication, (d) conflict resolution, (e) financial management, (f) leisure activities, (g) sexual relationship, (h) children and marriage, (i) family and friends, (j) equalitarian roles, and (k) religious orientation. An additional scale, idealistic distortion, adjusts the individual scores for social desirability. Both members of the couple are administered the inventory and receive individual scores for each of the 12 scales. For each of the relationship

scales, a Positive Couple Agreement (PCA) is generated, which identifies the areas where the couple reach a positive consensus.

FOCCUS, like PREPARE, is also an inventory used to evaluate the strengths and weaknesses in a couple's relationship. As of 1995, FOCCUS was the premarital inventory most often used by the Roman Catholic Church (Williams & Jurich, 1995). FOCCUS measures the following 15 relationship areas: (a) personality match, (b) marriage covenant, (c) life style expectations, (d) communication, (e) friends and interests, (f) problem solving, (g) parenting, (h) religion and values, (i) second marriages (if applicable), (j) interfaith marriages (if applicable), (k) personal issues, (l) readiness for marriage, (m) finances, (n) sexuality, and (o) extended family. Although both PREPARE and FOCCUS demonstrated good predictive validity (Williams & Jurich, 1995), PREPARE also established internal consistency and test-retest reliability as well as concurrent validity (Larsen & Olson, 1989).

The use of assessment inventories in premarital counseling is not uncommon. Boughner, Hayes, Bubenzer and West (1994) found that 20% of marriage and family clinicians used at least one inventory in working with premarital couples, with PREPARE cited as the fourth most frequently used inventory behind the Myers-Briggs Type Indicator (MBTI), the Taylor-Johnson Temperament Analysis, and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). The primary use of premarital assessment instruments in therapy was for educative/consultation purposes (Boughner et al., 1994).

Premarital Assessment Program

Buckner and Salts (1985) outlined one example of a premarital preparation program which aimed to assess a number of subject areas in seven sessions with individual couples over a period of twelve weeks. This sample premarital assessment program begins with an introductory session where the goals, purposes, and requirements of the program are described to the couple, and then the couple complete Stuart's Premarital Counseling Inventory. The foci of the subsequent sessions are as follows: session one, dating history and wedding plans; session two, expectations, roles, needs, and goals of the marriage; session three, family, finances, friends, and fun; session four, parents meeting; session five, communication and conflict; and for session six, values and sexuality.

After the sixth session, the therapist provides the couple with a written assessment summary. This includes the significant strengths, resources, potential liabilities in the relationship; degree of maturity, awareness of relationship issues, commitment to the marriage; possible impediments to a well-functioning marriage; and prognosis and recommendations for the couple (Buckner & Salts, 1985). The seventh session is conducted with the couple approximately three months after the wedding, to evaluate what the couple learned from the premarital assessment program and to assist the couple with any new difficulties they might be experiencing.

The assessment program is a joint endeavor between the therapist and the couple, although the sequence and amount of time spent on each topic is to be determined according to the couple's needs (Buckner & Salts, 1985). Even though the format of each session was consistent, including a wrap-up of the previous session, discussion of homework assignment, introduction of new topic, and assignment of new homework, Buckner and Salts described the particular goals, topics/techniques, assessment issues, questions, and homework assignments unique to each session.

The benefits of this particular premarital assessment program, according to Buckner and Salts (1985), were the couple's increased understanding of themselves, of their future spouses, of their relationship dynamics, and of the strengths and areas for growth in their relationship, clarification of issues not previously discussed, and increased likelihood of seeking assistance with any marital difficulties in the future. Although Buckner and Salts described one form of premarital assessment program, alternative programs, similar in style and content, have been offered by Nickols, Fournier, and Nickols (1986) and Russell and Lyster (1992).

Conclusion

There are a wide variety of assessment inventories appropriate for use in premarital counseling or in a formal premarital preparation program. Two examples of useful premarital assessment inventories are PREPARE and FOCCUS. Both PREPARE and FOCCUS have established predictive validity in

determining successful marital outcomes (Larsen & Olson, 1989; Williams & Jurich, 1995). The premarital preparation program highlighted specific relationship areas which are relevent for couples about to be married and provided a framework in which to assess these areas with an engaged couple. This digest has presented some information regarding a relatively neglected area of study in order to call attention to the need for preventative counseling and preparation programs which could help strengthen families of tomorrow.

References

Boughner, S. R., Hayes, S. F., Bubenzer, D. L., & West, J. D. (1994). Use of standardized assessment instruments by marital and family therapists: A survey. Journal of Marital and Family Therapy, 20, 69-75.

Buckner, L. P., & Salts, C. J. (1985). A premarital assessment program. Family Relations, 34, 513-520.

Larsen, A. S., & Olson, D. H. (1989). Predicting marital satisfaction using PREPARE: A replication study. Journal of Marital and Family Therapy, 15, 311-322.

Nichols, S. A., Fournier, D. G., & Nichols, S. Y. (1986). Evaluation of a preparation for marriage workshop. Family Relations, 35, 563-571.

Russell, M. N., & Lyster, R. F. (1992). Marriage preparation: Factors associated with consumer satisfaction. Family Relations, 41, 446-451.

Shack, J. R. (1989). Nonmarital partnerships. In Couples counseling: A practical guide for those who help others(pp.122-143). New York: Continuum

Silliman, B., & Schumm, W. R. (1989). Topics of interest in premarital counseling: Clients' views. Journal of Sex and Marital Therapy, 15, 19-206.

Williams, L., & Jurich, J. (1995). Predicting marital success after five years: Assessing the predictive validity of FOCCUS. Journal of Marital and Family Therapy, 2, 141-153.

Running head: ASSESSMENT OF DIVORCE READINESS

Assessment of Couple Readiness in Divorce And Practical Implications for Counselors

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Assessment of Couple Readiness in Divorce and Practical Implications for Counselors

Counselors are frequently required to make judgments about when couples are ready to undertake the mechanics of divorce. Assuming that a marriage has passed the point of no return, the faster a couple negotiates a settlement that resolves issues of children, money and property, the faster the family can begin to heal and adapt. If the couple is able to negotiate a fair settlement quickly and without bitter litigation, the chances of divorce related pathology are radically reduced (Margulies, 1992).

It can fairly be said that the negotiation of an equitable settlement agreement is the final task of the marriage. The settlement can be done with the help of lawyers, by the couple themselves, with the help of a mediator or any combination of these. However it is done, the clinical task is to help the couple stay in control of the potential bitterness that not only cause ugly litigation but leaves the divorced couple bitter, emotionally and financially drained, and unable to parent cooperatively and effectively.

The critical dynamic to recognize in a couple on the cusp of divorce is the difference between the initiator and non initiator of the divorce (Margulies, 1992; Vaughn, 1990). Very few divorces are marked by mutuality when it comes to the decision to divorce. Almost invariably one member of the couple reaches a decision first, which may or may not be communicated to the other. The initiator typically goes through a process of initial grief with the realization that the marriage will not work. He or she may experience deep disillusionment followed by resolve for change followed by planning for a life without the other spouse. The initiator may "try on" many imaginary life scripts and gradually create an image of a full and satisfying life without the spouse. He or she may begin to develop a new and separate life with new interests, new friends, and perhaps a new relationship which provides intimacy and emotional support. Thus, in many cases, by the time the initiator says "I want a divorce", he or she may have been working on the decision for years. For the initiator most of the work of grieving the marriage and planning the future has been completed, and the losses associated with divorce have been put into perspective by the gains of a new life.

The problematic partner in divorce is the non initiator, for he/she is in an inferior psychological position. Non initiators span a broad emotional

spectrum. On one extreme is the partner who has seen the deterioration coming for years and though perhaps wishing for one more chance at working it out, quickly accepts the divorce as inevitable and perhaps even a good idea. On the other extreme is the spouse who is thunderstruck - totally taken by surprise. For this spouse, the divorce is the beginning of a long nightmare for which he/she is not at all ready. Unlike the initiator, this spouse has not had time to work through any of the issues of rejection, disillusionment, or loss. He/she still wants the marriage and experiences the news of divorce as worse than the sudden death of the spouse since the loss is accompanied by profound rejection. As he/she gradually realizes that the other has been thinking and planning this for a long time, intense feelings of rage and betrayal develop that frequently cause acting out and aggressive litigation. Panic, humiliation, and a sense of abandonment are experienced. Readiness to begin divorce negotiations is a function of the state of mind of the non initiator. Though the initiator is ready to negotiate, he/she must come to understand that the other spouse may not be ready, and if pushed, will become more recalcitrant and hostile (Ahrons, 1995; Margulies, 1992).

The non initiator must be given time to work through his/her grief and an opportunity to talk to the initiating spouse. Commonly, the non initiating spouse will plead for an attempted reconciliation, a plea that often leads to a half hearted attempt motivated by appeasement rather than a genuine desire on the part of the initiator. Since the relationship has been so badly damaged, reconciliation almost always fails, leading to an even greater sense of betrayal because the other did not "try hard enough."

It is in the management of this period that the counselor can make a critical difference. The counselor provides reality testing for the non initiator to help him/her accept the inevitability of the divorce and to shift the focus from the past to planning for the future. The counselor will also help the initiator to be patient by reframing and translating the feelings of the non initiator into understandable concepts. Too often the initiator, eager for closure, interprets the non initiator's resistance as sabotage rather than lack of readiness. The counselor also provides the couple an opportunity to talk in a safe setting about their feelings to gain emotional closure, and can direct the couple to choose non destructive forms of negotiation such as mediation rather than litigation. Another role of the counselor is to monitor many of

the things couples do at this stage that produce confusion and ambivalence, such as still sleeping together and having sex with each other.

Readiness Tasks and Indicators

The initial shock of divorce produces great disarray in many non initiators so that rage, panic, and acting out are common. For the non initiator, divorce means that life is going to get worse. It represents only loss - "of status, economic security, identity, contact with children, and place in the community. Because the non initiator does not see how divorce will improve his/her life, the motivation to adapt is generally lacking" (Margulies & Luchow, 1993, p. 486). As in any other grieving process, time eventually brings a sense of resignation and ultimately acceptance. The initial period of shock and disorganization is clearly not the time to initiate divorce. The counselor needs to check out whether or not this period has ended and whether the non initiator, though sad, has calmed down. The indicator is the affect the client presents in the first meetings. Rage and anger are replaced by sadness, resignation, and acceptance if the non initiator is ready to proceed with divorce (Ahrons, 1995; Margulies & Luchow, 1993).

The degree of separation achieved by the couple is a primary indicator of readiness to negotiate. The most complete expression of separation is a physical separation represented by two separate residences. But some couples may be ready to negotiate even though they are living in the same house. Lawyers may have instructed them not to move, or finances may be in such disarray that they have not yet figured out how to afford two residences. Moreover, the couple may be in conflict over how they are going to parent the children, and therefore each is reluctant to move less the move is seen as an abandonment of parental rights. Short of separate residences, one looks to see if couples have separated within the house. Separate bedrooms are the general indicator that this has occurred. However, even couples who are in the same bedroom may be ready to negotiate. The fact that they are in the same bedroom may simply reflect a struggle over who will keep the bed and who gets the couch. The counselor must inquire and assess these indicators. A minimal prerequisite is that the couple has stopped having sex. Couples in the same bed who continue to have sex are not ready to negotiate a separation agreement.

In most divorces atleast one if not more attempts at reconciliation is nearly universal. This may arise from two factors. First, the non-initiator

pleads with the initiator to try reconciliation one more time. This would typically include a request that the couple go into counseling if they are not already in counseling. The initiator frequently hopes that by going into counseling he/she will recruit the counselor as an ally in convincing the non initiator that the marriage cannot work. At a minimum going into counseling provides a place to "park" the non initiator when he/she falls apart emotionally. Second, the initiator frequently has a need to prove to the non initiator that reconciliation will not work, and so this final attempt at reconciliation is designed as the ultimate proof that the decision to divorce is correct. Invariably reconciliation fails because it was attempted in the face of a terminally damaged marriage. Not infrequently failed reconciliation leaves the non initiator even angrier than he/she was before because the non initiator may now believe the initiator never intended for the reconciliation to work and thus he/she has been betrayed one more time. Nevertheless, as long as the impulse to reconcile is alive, the non initiator is generally not ready to accept divorce (Margulies & Luchow, 1993; Vaughan, 1990).

A simple check for the counselor is to ask the initiator in the presence of the non initiator two questions: "Is this marriage irrevocably over?" Assuming the answer is "Yes", the second question is , "Is there anything your spouse can do or say that can cause you to change your mind?" Assuming the answer to this is "No", the non initiator has no choice but to deal with the reality of the divorce. On the other hand, if the answer to either of these questions is that the marriage is not irrevocably over, or that there are specific things the non initiator can do to induce the initiator to change his/her mind, then the couple needs more counseling before they are ready to negotiate a settlement. A spouse indicating that the decision is not irrevocable and that specific acts by the non initiator can induce the initiator to change his/her mind may be using the threat of divorce as a gesture to "shape up" the other spouse. Using the threat of divorce as a gesture may, at some level, show that the initiator does not really want divorce. Obviously, this situation is an indicator of non readiness to divorce. In summary, an indicator of readiness is when talk of reconciliation has ended, and the initiator says and the non initiator hears that the decision to divorce is irrevocable.

Very often the non initiator does not yet understand why the initiator wants a divorce. From the non initiator's perspective the decision of the spouse constitutes a massive rejection that arouses all the non initiator's

defenses. The non initiator may explain the initiator's decision to divorce in terms of the other spouse's confusion, temporary insanity, irresponsibility, mid-life crisis, or any other premise that invalidates the initiator's desire to divorce. Behind these defenses the non initiator takes refuge from the reality of divorce and insists he/she does not understand and that divorce makes no sense. Because divorce makes no sense, the non initiator has no reason to accept it and thus continues to resist. The non initiator needs an opportunity to hear the initiator's determination as well as the reasons why the initiator wants out of the marriage. The non initiator needs an opportunity to express his/her disagreement, disapproval, dismay, and despair. Only after the non initiator has been heard and only after the initiator acknowledges that he/she has heard and understands the non initiator's feelings will the initiator be ready to state that he/she indeed is determined and the divorce will occur, notwithstanding the other spouse's disagreement. The counselor needs to find out if these discussions have occurred; and if they have not, the counselor needs to provide leadership until closure is obtained.

A critical aspect of readiness is a cognitive shift from the past to the future. When a couple is ready to negotiate a settlement, they have begun to look forward and deal with the problems they will encounter as single people. This will involve for atleast one member of the couple a move to a new residence. A positive sign of a person's readiness is if the individual moving out has begun to research alternative housing. Second, divorce changes people's social life. Old friends whose relationships are premised on the existence of a couple may drop away. New friends and new social opportunities may be called for. The counselor needs to assess whether non initiators have begun to look for social support, have joined support groups, or identified some friends who provide support. For many women who have had part time careers or have been at home with the children, the economic realities of divorce require a resumption of a career. The failure to start looking at this does not necessary mean that the couple is not ready but an investigation into alternatives is an affirmative indicator of readiness. In summary, readiness is indicated when the non initiator has the opportunity to begin planning for another dwelling (or the other spouse moving into a separate dwelling), a reorganized social life, and a new or resumed career.

Divorce readiness tasks and indicators can be summarized in five categories: The initial period of shock and disorganization has passed, and

sadness over loss and resignation have replaced anger and rage; emotional separation has occurred as indicated by cessation of sex and separate bedrooms or dwellings; talk of reconciliation has ended and both parties understand that the decision to divorce is irrevocable; the non initiator has had the opportunity to talk through the divorce and be heard by the initiator; and the non initiator has begun planning for a separate dwelling, reorganized social life, and new or resumed career. A counselor can provide a valuable service in assessing the readiness of couples to divorce. With counseling, couples can clarify their readiness, expectations, and tasks required in successful divorce, improve their communication, and move forward in the healing and adaptation process.

Resource Documents

Ahrons, Constance. (1995). The good divorce. Scranton, Pa: Harper & Row.

Friedman, James T. (1982). The divorce handbook. New York: Random House.

Margulies, Sam. (1992). Getting divorced without ruining your life. New York: Simon and Schuster.

Margulies, Sam, & Luchow, Anya. (1993). Litigation, mediation, and the psychology of divorce. Journal of Psychology & Law, Winter, 483-504.

Neely, Richard. (1984). The divorce decision. New York: McGraw-Hill.

Vaughan, Diane. (1990). Uncoupling. New York: Random House.